STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of MO
Hearing dates:	7-8 November 2023 Lismore Local Court NSW 9 November 2023 Byron Bay Local Court
Date of findings:	26 March 2024
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	**Deputy State Coroner Carmel Forbes**
File number:	2018/250795
Catchwords:	CORONIAL – death of six-year-old boy of a methadone overdose in his home – Opioid Treatment Program – prescribing of takeaway methadone – Department of Communities and Justice enquiries into safety of takeaway methadone use and storage by parents
Representation:	Mr M Dalla-Pozza Counsel Assisting, instructed by Ms G Buchan and Ms L Carter, NSW Crown Solicitors Office. Mr B Bradley representing the NSW Ministry of Health, instructed by Mr M Renwick, McCabes Lawyers. Mr M Hutchings representing the NSW Department of Communities and Justice, instructed by Ms M Panos and Ms M Windsor, Norton Rose Fulbright.

	Mr M Lynch representing Dr McGeown, instructed by Ms L Kearney, Avant Mutual. Mr B Wilson representing Ms S Letton, instructed by Mr S Fitzgerald, Meridian Lawyers. Mr J Sproule representing Ms N Oaten, instructed by Mr P Boardman and Ms G Young, Clyde & Co.
Findings:	***Identity*** The person who died was MO. ***Date of death*** MO died on 6 August 2018. ***Place of death*** MO died at Lady Cilento Children's Hospital, South Brisbane, QLD. ***Cause of death*** MO died as a result of methadone toxicity. ***Manner of death*** MO died after ingesting take away methadone in his home.
Non-publication orders:	Final non-publication orders were made on 7 November 2023 prohibiting the publication of the names or any other information (including photographs) that tends to identify MO; MO'S parents; MO's siblings; MO's cousin; and the makers of any risk of significant harm (ROSH) reports in relation to MO or his siblings. A copy of the non-publication orders can be obtained on application to the Coroners Court Registry.

INTRODUCTION

1. This is an inquest into the very sad death of MO. MO died on 6 August 2018. He was only 6 years of age at the time of his death. He died after ingesting methadone in his family home. Both of his parents were on the NSW Opioid Treatment Program (OTP) and were prescribed takeaway doses of methadone.

2. MO had come to the attention of the Department of Family and Community Services (FACS) now the Department of Communities and Justice (DCJ) in 2015. At the time of his death the family file had been closed.

3. An inquest is a public examination of the circumstances of a death. This inquest is being conducted in accordance with the *Coroners Act 2009 NSW* (the Act). Section 81 of the Act requires a Coroner, at the conclusion of the inquest, to make findings as to:

    a. The identity of the deceased person;
    b. The date and place of the person's death; and
    c. The manner and cause of the person's death.

4. The focus of an inquest is on discovering what happened, not on ascribing guilt, attributing blame, or apportioning liability. If the evidence justifies it a Coroner may then go on to make recommendations about matters of public health and safety that arise out of the death in question.

5. In relation to MO's death the main issue is whether anything more could be done by those involved in administering the OTP to prevent a similar death in similar circumstances in the future.

6. There have unfortunately been previous matters considered by this court where children have died as a result of ingesting takeaway methadone. This makes it important that, if there were any deficiencies or failings in the events leading up to MO's death, these be identified, and appropriate lessons learned.

MO

7. MO suffered from epilepsy which was diagnosed when he was aged two and attention deficit hyperactivity disorder.

8. Both of MO's parents – but particularly his mother – suffered from cognitive and/or intellectual impairments. Cognitive testing performed on his mother in 2017 placed her in the bottom 3 percent putting her in the borderline range in general cognitive ability. The test concluded that the mother "*will need written prompts and routine reminders when dealing with numbers [and she] may need assistance with dosing medications.*"[1] Further cognitive testing in March 2019 placed her in an extremely low range of cognitive functioning with significant deficits in all skill domains, and in the mild deficit range of intellectual disability.[2]

9. In December 2013, MO was admitted to hospital having ingested medications when on a camping trip with his family. His parents initially indicated to the hospital that the medications belonged to someone else though, subsequently, his parents acknowledged they were their medicines.[3]

10. MO's father had a long-standing addiction to pain relievers and was on the OTP.

11. Prior to 2016, MO's father was being treated with suboxone, a combination of buprenorphine mixed with naloxone. Suboxone is said to have some benefits in terms of reducing overdose when compared with other opioid treatments such as methadone or sublingual buprenorphine.

12. On 28 September 2016, MO's father first saw Dr Paul McGeown a specialist in addiction medicine. On 26 October 2016, Dr McGeown changed his medication from suboxone to subutex (oral buprenorphine) on the basis that he was experiencing headaches. On 11 October 2017, the subutex was substituted with methadone. By 22 May 2018, the methadone prescription was increased to a dosage of 190mg.

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[1] Exhibit 1 Vol. 7 Tab 118 p. 607

[2] Exhibit 1 Vol. 7 Tab 118 p. 607

[3] Exhibit 1 Vol. 2 p. 663

13. Significantly MO's father was permitted to administer some of those medications by takeaway, meaning that he did not take them supervised by the dispensing pharmacy. By 16 October 2017, he was permitted 4 takeaways per week, which increased ultimately to 6 weekly takeaways at the time of MO's death.

14. Dr McGeown first saw MO's mother on 30 April 2018. Dr McGeown recorded that her husband was on the OTP. He also recorded that "*some taxing happens*" and the mother was using 50-60mg of the methadone. The reference to taxing, together with the reference to the mother's morphine use, is understood to refer to his mother diverting some of MO's father's methadone.

15. Dr McGeown prescribed MO's mother methadone at 40mg. Initially she was permitted "*2 takeaways plus public holidays*". The mother's dose was increased and at the time of MO's death was 130mg per week.

16. By the time of MO's death, his mother was permitted to administer the methadone by way of 6 takeaway doses.

17. A total of 12 takeaway doses per week were going to MO's home at the time of his death.

DR MCGEOWN

18. In the ordinary course of events Dr McGeown would have been called to give evidence in this inquest.

19. Dr McGeown does not currently practice medicine. He surrendered his registration to the Australian Health Practitioner Regulation Agency on 11 February 2022. He had been the subject of the attention of the medical regulatory bodies. I have been informed he will not be re-applying for registration again in the future. An application was made by his lawyers for him to be excused from attendance at this inquest on the basis that he is unfit to attend court. His application was supported by a medical report by his treating doctor. I am satisfied that his medical condition denies him the capacity to be a competent witness.

20. The brief of evidence tendered at the inquest contained his treating medical records and his prescribing history to both of MO's parents. These are all relevant as it is appropriate to look at the whole picture that relates to all of the methadone that was in MO's home. From the criminal proceedings against MO's parents, the inquest had before it an account of how MO came to ingest methadone, but that account has never been tested and any methadone that was in his home is relevant for consideration.

21. An independent expert, Dr Emery Kertesz, has reviewed Dr McGeown's treating medical documents. Dr Kertesz is a medical practitioner who has been involved in opioid treatment since 1990.

WOLLONGBAR PHARMACY

22. At the time of MO's death, the OTP medication being prescribed to both his father and mother was being dispensed by a pharmacist employed at Wollongbar Pharmacy (the Pharmacy). Ms Natalie Oaten was, at the time, the owner of the Pharmacy.

23. In the course of receiving his OTP treatment, MO's father signed a "Pharmacy Dosing Contract" with the Pharmacy on 30 December 2015, which was a proforma from the Pharmacy Guild of Australia (NSW). Through this contract he committed to be responsible for takeaways and dispose of bottles appropriately. On 10 November 2016, MO's father signed a replacement contract with the same provisions and some additions, including a commitment to ensure takeaways are stored safely and locked away from others especially children.

24. MO's mother also signed a contract with the Pharmacy when she commenced on the OTP on 1 May 2018. It was identical to the father's second contract but with one extra stipulation: that the Pharmacy operates a one-strike policy and if the rules are broken, they need to find another dosing pharmacy.

25. Methadone was administered by the Pharmacy in bottles which contained the following labels:

> "KEEP OUT OF REACH OF CHILDREN MAY CAUSE DEATH OR HARM"

DEPARTMENT OF COMMUNITIES AND JUSTICE

26. In 2015 MO and his two siblings came to the attention of DCJ after receiving a risk of significant harm (ROSH) report. There were other ROSH reports in the years prior to MO's death, mainly with concerns relating to neglect. There were, in broad terms, two matters that the ROSH reports raised:

    a. Educational neglect – poor school attendance; and

    b. Condition of the physical premises at home.

4 AUGUST 2018

27. MO's parents provided the following explanation as to how MO came to ingest methadone. They said that on 4 August 2018 MO ingested some of his mother's methadone dose, which was mixed in a glass of orange juice. He consumed an indeterminate amount.

28. At this time MO's parents were taking one observed dose of methadone at the Pharmacy each week and were given 6 takeaway doses each. They say that they stored them in a locked box, and they had told their children not to go near the box and not to drink from their parents' cups.

29. When police attended the premises in the course of investigations, the father showed them the locked box, which the police broke into because the parents had misplaced the key.

30. The father estimated that if MO had indeed ingested any methadone, it would have been 20-30mg. He was aware that this was *"quite a lot for a little boy"*. He was also aware methadone ingestion by a child could be life-threatening. However rather than seek medical advice or attention, the father decided they would monitor MO for the symptoms and signs they expected to see if he had consumed methadone, such as drowsiness, dizziness and vomiting. The parents kept MO up until 10:00pm to observe and withheld his regular epilepsy medication (Keppra). They noted that MO did not become drowsy but was tired and said he was dizzy, however he often said this if he had

not been wearing his glasses. MO also complained of a bad headache, which, on the father's evidence, falsely reassured him that MO was unlikely to have had any methadone given its analgesic properties.

31. At around 6:30am on 5 August the parents said they woke to find MO unresponsive with laboured breathing. MO had vomited overnight.

32. The father called an ambulance and said at the outset that MO had epilepsy and it was suspected he had had some methadone. The operator did not respond to the methadone reference and all the questions and advice that followed related to seizures.

33. Ambulance officers attended the home and on arrival were told by the father that MO may have drunk some methadone that was in a glass of orange juice. After observing that MO's pupils were pinpoint, that he was unconscious, hypo ventilating and cyanosed, the ambulance officers decided that MO was suffering an opioid overdose.

34. The ambulance officers gave MO two doses of naloxone, which improved his condition temporarily.

35. MO was taken to Lismore Base Hospital where his condition deteriorated, and he was transferred to Lady Cilento Children's Hospital in Queensland later that day. CT and nuclear medicine scans showed no cerebral perfusion, and he was pronounced 'life extinct' at 10:43am on 6 August 2018. At post-mortem the cause of death was determined as hypo-ischaemic encephalopathy due to or as a consequence of methadone toxicity.

36. Police attended the family address on 5 August and spoke to MO's father (his mother was at the hospital). His father was unable to locate the glass or cup that had contained the juice and methadone.

37. Police charged each of MO's parents with one count of fail to provide for child, cause danger or death. Both pleaded guilty and these matters have been dealt with by the courts.

38. The parents were not called in this inquest and there will be no detailed examination of their involvement. They have been dealt with already by the criminal justice system.

39. After MO's death Dr McGeown initially ceased all takeaways for the parents. However, he reinstated them on 11 September 2018, then reduced them to 3 per week when FACS raised a concern about the father's alcohol consumption.[4] In November 2018 each were receiving 4 takeaway doses per week.

ISSUES

40. An issues list was prepared prior to the inquest commencing to provide structure to the hearing. Some of the issues are no longer of great relevance and other issues have emerged during the inquest. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

Methadone that was prescribed to MO's parents

41. The medical records provide the following history of prescription by Dr McGeown to MO's father:

- He increased subutex from 8mg to 32 mg between 21 and 22 March 2017.
- He increased methadone from 90mg to 130mg between 7 November 2017 and 5 December 2017 (initially in increments of 10mg every 3 days followed by increases of 15 mg every 5 days).
- He increased methadone from 145mg to 190mg between 21 February 2018 and 2 March 2018.

42. Dr Kertesz, the independent expert who reviewed Dr McGeown's medical records, is of the opinion that all of the above increases were outside the *NSW Clinical Guidelines: Treatment of Opioid Dependence* (OTP Guidelines). He is critical of the rates of increase

[4] Exhibit 1 Vol. 2 pp. 374-376 and 419; Ex 1 Vol. 1 p. 280

and described them as being significantly below the standard expected of an OTP prescriber. He told the Court:[5]

> *"I think the increments that Dr McGeown used were excessive, they were outside the guidelines, they were significantly higher than practitioners of his experience and knowledge, significantly higher than other practitioners of equal level of practice would have used. I personally have never used those increments in 20-odd, 25 years of prescribing because of the inherent danger of the drug."*

53. Dr McGeown prescribed MO's mother methadone at 40mg and initially she was permitted *"2 takeaways plus public holidays"*. The mother's dose was increased and at the time of MO's death was 130mg per week.

54. Dr McGeown made no clinical notes that he considered the significance of MO's mother's intellectual disabilities when he prescribed her methadone. It is possible he was not aware of her disabilities. However, the results of her psychological assessments are clear, and I accept Dr Kertesz's opinion that her intellectual disability should have been considered before she was prescribed methadone and in particular takeaway methadone.

55. A central issue in this inquest is the appropriateness of Dr McGeown prescribing takeaway methadone doses for MO's parents. It is relevant and appropriate for this inquest to consider all of the methadone going into his home.

56. The OTP Guidelines provide guidance as to the circumstances when takeaways are and are not appropriate and the number of takeaways permitted; a clinical decision to depart from that guidance is to be the subject of a careful consideration and weighing up of the risks against the perceived benefits to the patient.

57. The OTP guidelines provided for no more than 4 takeaways per week in the case of a person other than a person who is at moderate or minimal risk absent special

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[5] Transcript Day 3, 27:12

circumstances. Dr Kertesz gave evidence that special circumstances may arise where the person was a carer, was in full time employment, had multiple children in the house or lived 25 to 30 kilometres from an OTP pharmacy.

58. Dr Kertesz is of the opinion that Dr McGeown's decisions in June 2018 to increase MO's mother's prescription to 6 takeaway doses per week and in September 2016 to increase MO's father's prescription to 6 takeaway doses per week were not appropriate. He is of the opinion that there is nothing in either of the parents' circumstances that justified a reason for that level of takeaways. He does not accept that Dr McGeown's note that the distance of travel for MO's parents was justification for the extra takeaway doses. MO's parents lived 15 minutes away from the Pharmacy. Dr Kertesz is of the opinion that 6 takeaway doses for each of MO's parents amounted to an unjustified departure from the OTP Guidelines. They had a car and they lived 15 kilometres from the Pharmacy.

59. Twelve doses of takeaway methadone were going into MO's home each week. His mother had an intellectual disability. There is evidence that the house was chaotic. This was a high-risk situation for MO.

60. I note that Dr McGeown has now surrendered his registration as an Australian Health Practitioner, and he has informed this Court that he will not be reapplying for registration again.

Dispensing pharmacies

61. In order to be a dosing point for the dispensing of methadone (and buprenorphine), the Pharmacy needed approval from the Pharmaceutical Regulatory Unit (PRU) of the NSW Ministry of Health (MOH). On 16 November 2012, 6 years before MO's death the registered owner of the Pharmacy applied for an approval.

62. On her application form Ms Oaten made the following declaration and undertaking:[6]

[6] Exhibit 8A

"I and all registered pharmacists under my employ have read and have understanding of the latest edition of the NSW Ministry of Health Guideline TG201 "Supply of Methadone and Buprenorphine under the New South Wales Pharmacotherapy Drug Treatment Programs – Guidelines for Community Pharmacists."

"I hereby give an undertaking that methadone and/or buprenorphine will be handled and administered by pharmacists at my pharmacy in accordance with the above-mentioned guideline TG 201/1."

63. The owner of the Pharmacy gave evidence in the inquest that she kept a hard copy of the OTP Guidelines and the NSW Opioid Treatment Program Community Pharmacy Dosing Protocol in a folder in the Pharmacy and electronically in an email folder.

64. In January 2018, Ms Stacey Letton commenced employment at the Pharmacy and began dispensing opioid replacement medications. She dispensed methadone to MO's parents on a weekly basis. She gave evidence in the inquest that she was not aware of the OTP Guidelines. She does not recall being given any induction regarding the OTP Guidelines.

65. This scenario raises the question of whether the declaration and undertaking given by a pharmacy owner at one point in time is adequate or effective when they might have a high turnover of employees over years. Particularly when the owner of the pharmacy doesn't work at the pharmacy. The declaration should state more clearly and reinforce the continuing obligation of the applicant.

66. Ms Letton told this court that she thought that there should be a better system in place that ensures that employed pharmacists who are required to practise within the OTP Guidelines and have responsibility placed on them by those guidelines are required to acknowledge in writing that they are aware of the guidelines. She has worked as an employed pharmacist at various pharmacies over the years. Sometimes for a short period as a fill-in while other staff are away. Sometimes she is asked to dispense methadone. Often the owners of the pharmacy do not work at the pharmacy.

67. I agree with her that there needs to be a more robust system in place to ensure that those who are authorised to dispense methadone on a daily basis at a pharmacy have acknowledged in writing that they are aware of their responsibilities and of the OTP Guidelines.

Opioid Treatment Program Guidelines

68. The MOH has commissioned experts to conduct a review of the OTP Guidelines.[7] Mr Madeddu, the Executive Director at the Centre for Alcohol and Other Drugs (CAOD) (a unit within the MOH) has informed the Court that the review is being coordinated by the Clinical Policy Unit at the MOH, which will bring together relevant expert clinicians and stakeholders to facilitate a clinical consensus. An expert steering committee will be formed in early 2024, which will comprise clinicians with expertise in alcohol and other drugs, addiction medicine, intensivists, pharmacologists, and toxicologists. The review will be led by the Chief Addiction Medicine Specialist, NSW Health. Mr Madeddu anticipates that child safety will assume a high priority in the review. A revised draft of the OTP Guidelines is anticipated by mid-2024.

69. The review will consider issues that have been raised by the circumstances of this inquest. Mr Madeddu confirmed that the review will consider the findings made by this Court in relation to the circumstances of MO's sad, untimely and unnecessary death.

70. The following topics are a few that the review of the OTP Guidelines should consider:

    a. The declaration on the application for authority to dispense methadone should be reworded to give clarity to the ongoing nature of the pharmacist's responsibilities to ensure that both they and any of their current employees or those employed in the future who dispense methadone are aware of the OTP Guidelines. Furthermore, any pharmacist dispensing methadone as either an employee or employer should have signed the Guidelines acknowledging in writing that they are aware of them.

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[7] Exhibit 13

b. The practice of mixing takeaway doses of methadone with orange juice or some other drink to mask methadone's foul taste. Both Dr Kertesz and Ms Letton gave evidence that, in their respective experience, this is a reasonably common practice. Further, both Dr Kertesz and Ms Letton have explained that, in the case of takeaway doses, neither the prescriber nor the dispenser have any control as to the manner in which that dose is consumed. The evidence of both Dr Kertesz and Ms Letton illustrates the need for any consumer of opioid replacement medication who is permitted to consume that medication via takeaways to receive appropriately firm advice (from both the prescriber and the dispenser) of the dangers of mixing methadone with orange juice or other drinks and, in particular, of leaving that mix unattended or in reach of children. Those dangers are tragically illustrated by the circumstances of MO's death. Whilst precisely what occurred before MO consumed the methadone is not entirely clear, a strong possibility is that the juice with methadone was left unattended for a period and MO consumed it. The OTP Guidelines would appear to be the principal source of guidance to both the prescriber and the dispenser about these risks (and consequently, of the advice that the prescriber and dispenser should give to the consumer in this regard). At present, the guidelines are silent as to the potential risks of mixing methadone with orange juice or other drinks (in terms of accidental ingestion, particularly by a child). This matter is addressed, briefly, in a consumer guide,[8] but as that is a lengthy document, this advice might not be a substitute for the consumer receiving appropriate advice from either the prescriber or the dispenser.

c. The OTP Guidelines might offer greater guidance to a prescriber relating to the administration of opioid replacement medication to persons with an intellectual disability. In particular, the prescriber may require particular guidance regarding the circumstances when it may (and may not) be appropriate to approve takeaways to persons with intellectual disabilities,

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[8] Exhibit 1 Vol. 4, Tab 55 [23]; Vol. 4, Tab 55(d), p. 408

particularly in circumstances where there are children present in that person's household. Similarly, a dispenser may also require guidance about this topic; whilst the dispenser is not responsible for making decisions about takeaways, at times, it may be appropriate for the dispenser to contact the prescriber to query such a decision.

d. The OTP Guidelines do not presently provide guidance to a prescriber or dispenser as to the advice they should give a methadone consumer as to the steps they should take in the event that the consumer suspects ingestion of their methadone by a child. In particular, that advice should emphasise the utmost importance of seeking urgent medical attention by calling Triple 0. The need for such guidance and careful consideration of this issue is thrown into sharp relief by the circumstances of MO's death. The evidence is that even though MO's father formed a suspicion that it was possible that MO had consumed methadone he decided to monitor MO overnight, rather than seek immediate medical attention.[9] It is a possibility that the parents did not seek medical attention for MO earlier because they were concerned the children would be removed from their care and/or that they may be excluded from the OTP. It is also possible MO's father did not understand how toxic a small amount of methadone is for a child. All these possibilities need to be considered.

e. The Court received into evidence a flyer from DCJ's "Alcohol and Other Drugs Kit" (AOD Kit) regarding the safe storage of methadone and buprenorphine.[10] It also sets out safety procedures if a child ingests methadone. When taken to that flyer, Dr Kertesz remarked that it was an "*excellent*" resource which he recommended ought to be given to "*every single patient*" on the OTP. The patient could be encouraged to hang it next their storage cupboard at home.[11]

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[9] Exhibit 1 Vol. 4, Tab 7 AA pp. 92-101; 124

[10] Exhibit 11

[11] Transcript Day 3: 30-17

Department of Communities & Justice

66. On 5 May 2017, a ROSH report was made to DCJ via the child protection helpline in relation to MO and his family. The reporter drew attention to the children's patterns of attendance at school and levels of hygiene and that MO's father was on methadone.

67. On 15 June 2017, two caseworkers spoke with MO's father as he arrived to collect his children from school. He told them that he was taking a "*morphine equivalent*".[12] The workers then attended the home. The caseworkers observed the squalid nature of the premises.[13]

68. Earlier attendances by DCJ caseworkers (during August 2015) had also noted that the physical living conditions at the premises were "*hazardous*" and "*immediately threatening to the health and safety of the children*."[14]

69. Following the initial visit on 15 June 2017, a caseworker made a number of requests for information to various agencies pursuant to s. 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Through these requests, by 28 July 2017, DCJ became aware, amongst other things, that MO had needed to be hospitalised in December 2013 after experiencing an unusual seizure episode. The documents that became available to DCJ record that MO apparently accessed his parents' medicine box whilst on a camping trip. That medicine box included opioid medications.[15] DCJ also became aware of Ms O'Neill's level of cognitive impairment.[16]

70. In hindsight, MO's mothers' intellectual impairment, the 2013 incident and the hazardous living conditions that had been noted ought to have prompted curiosity about safety and risks in the home for the children.

71. The Court has been informed that since the date of MO's death there have been considerable improvements in the resources available to caseworkers regarding the

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[12] Exhibit 1 Vol. 5, Tab 61 [29]

[13] Exhibit 1 Vol. 5, Tab 61 [30]; Vol. 6, Tab 67

[14] Exhibit 1 Vol. 6, Tab 26, p. 133

[15] Exhibit 1 Vol. 5, Tab 61 [54]; Vol. 7, Tab 86, p. 517

[16] Exhibit 1 Vol. 5, Tab 61 [65], Vol. 7, Tab 188, p. 600

potential risks to a child associated with a parent or carer who is using opioid replacement medication. The training and guidance include prompts for a caseworker to take a more proactive approach to the risks of a child accidentally ingesting opioid medication in the future.

72. A copy of the AOD Kit,[17] which is an online resource for caseworkers has been provided to the Court. The AOD Kit gives guidance to caseworkers as to the potential safety risks associated with methadone. It addresses specifically the importance of the safe storage of methadone. Page 220 prompts a caseworker to make inquiries as to the following matters:

   - Are the parents receiving takeaway methadone or buprenorphine?
   - If so, can they show you where they store it?
   - Methadone must be stored in a locked box that is not easily accessible and not in the fridge. All medication should be kept out of reach of children.

73. These changes provide improved guidance to caseworkers as to when they ought to interrogate a potential risk associated with a child consuming methadone (or another opioid replacement medication). The new resources will prompt a caseworker to ask targeted questions and direct their attention to the particular safety issues that may be presented by takeaway methadone in the family home.

CONCLUSION

74. The upcoming review of the OTP Guidelines is an excellent opportunity to consider and ameliorate the very real risks to children of takeaway methadone being brought into the family home. I trust that an examination of the circumstances surrounding MO's death will guide the review in establishing a regime that will assist in preventing a similar tragedy in the future.

[17] Exhibit 10

Findings pursuant to s 81 (1) *Coroners Act 2009*

Identity

The person who died was MO.

Date of death

MO died on 6 August 2018.

Place of death

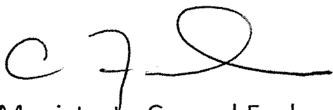
MO died at Lady Cilento Children's Hospital, South Brisbane, QLD.

Cause of death

MO died as a result of methadone toxicity.

Manner of death

MO died after ingesting his parents take away methadone in his home.



Magistrate Carmel Forbes

Deputy State Coroner

26 March 2024

NSW State Coroner's Court Lidcombe