CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Phoenix Hemmings
Hearing dates:	19 July 2022
Date of Findings:	19 August 2022
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, methadone prescription and dispensing, takeaway dose, opioid treatment program, safety assessment and safety planning for problematic alcohol and drug use
File number:	2015/96527
Representation:	Ms C Xanthos, Coronial Advocate Assisting the Coroner
Findings:	Phoenix Hemmings died on 31 March 2015 at Blacktown Hospital, Blacktown NSW 2148. The cause of Phoenix's death is methadone toxicity. It is most likely that Phoenix was administered a quantity of methadone by another person on 31 March 2015. There is no evidence to suggest that the methadone was administered with an intention to cause direct harm to Phoenix. Rather, the evidence suggests that the administration of methadone on this occasion was consistent with a practice that had been followed previously where methadone was administered to Phoenix for sedation purposes. The toxic effects of methadone administration to Phoenix had the unintended consequence of causing his death. The manner of Phoenix's death is, therefore, homicide.

Table of Contents

1. Introduction 1
2. Why was an inquest held? 1
3. Phoenix's personal background 2
4. Ms Stratton's and Mr Natsis' history of methadone use 2
5. The events of 31 March 2015 2
6. What was the cause of Phoenix's death? 3
7. Results of the subsequent police investigation 5
8. How did Phoenix come to ingest the methadone? 5
9. Prescription of methadone to Mr Natsis 7
10. Involvement of the Department of Families and Community Services with Phoenix 8
11. Findings 10
    Identity 10
    Date of death 10
    Place of death 10
    Cause of death 10
    Manner of death 10

1. Introduction

1.1 Phoenix Hemmings was just 14 months old when he died on the afternoon of 31 March 2015. He was found at home, with no signs of life, after having reportedly fallen asleep earlier in the day whilst lying on a sofa next to his mother. When Phoenix was found to be unresponsive emergency medical services were called and Phoenix was transferred to hospital. Despite resuscitation efforts Phoenix could not be revived and was, tragically, pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 As the cause of Phoenix's death was not immediately known, his death became reportable pursuant to the Act. The subsequent postmortem examination of Phoenix revealed that Phoenix died from the toxic effects of a drug which was not prescribed to him, but which had been used by both his mother and stepfather. The identification of this drug, which indicated that Phoenix had not died from natural causes, raised concerns for some degree of third party involvement in Phoenix's death.

2.3 In essence, it raised the question of whether Phoenix died, or might have died, as a result of homicide. Section 27(1)(a) of the Act makes it mandatory for an inquest to be held in such circumstances. In addition, as Phoenix and his parents had previously received casework support from the Department of Family & Community Services (as it then was) it became necessary to examine whether Phoenix was provided with a safe home environment which mitigated the risk that he would be exposed, either directly or indirectly, to the toxic effects of any illicit or restricted drug. For all of these reasons, an inquest into Phoenix's death was required to be held.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.5 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

3. Phoenix's personal background

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Phoenix was born on 14 January 2014 at Blacktown Hospital to his mother, Lisa Stratton. It is not known who Phoenix's father is. As Ms Stratton was taking methadone as part of an opioid treatment program during her pregnancy, Phoenix became methadone dependent upon his birth. He spent approximately two weeks in the special needs unit of Blacktown Hospital following his birth, before being discharged. After returning home, Phoenix had no known health issues.

3.3 Phoenix lived with his mother and her partner, George Natsis, at a property in Seven Hills (**the Seven Hills Property**). The home was a single story detached house with three bedrooms; one bedroom was used as a nursery for Phoenix with the other two bedrooms used as storerooms. Ms Stratton and Mr Natsis slept on sofas in the lounge room.

3.4 By all accounts, Phoenix was a happy, healthy and active toddler. There is little doubt that Phoenix brought much joy to those who loved him the most and that his heartbreaking loss is still felt most deeply.

4. Ms Stratton's and Mr Natsis' history of methadone use

4.1 Ms Stratton had been taking methadone as part of an opioid treatment program for approximately 10 years prior to 2014. By the time of Phoenix's birth in January 2014, Ms Stratton had gradually weaned herself off methadone.

4.2 Mr Natsis had been taking part in an opioid treatment program for longer than Ms Stratton. By the time of Phoenix's birth, and after, Mr Natsis remained on this program. He received oral and takeaway doses of methadone from his local pharmacy.

4.3 Relevantly, on Monday, 30 March 2015, Mr Natsis attended the pharmacy and was provided with a single oral dose and to takeaway doses for 31 March 2015 and 1 April 2015. Mr Natsis was scheduled to receive his next oral dose on 2 April 2015.

5. The events of 31 March 2015

5.1 The matters described below are based on the versions of events provided by Ms Stratton and Mr Natsis.

5.2 Phoenix woke up between about 7:30am and 8:00am. Mr Natsis fed Phoenix his breakfast, consisting of cornflakes and warm milk. At around 8:30am, Mr Natsis changed Phoenix's nappy.

5.3 At approximately 11:00am, Mr Natsis took Phoenix to the McDonalds at St Martins Village and purchased lunch via the drive through. They later returned home and had lunch with Ms Stratton. Phoenix ate five or six chicken nuggets and had some pre-prepared formula.

5.4 After lunch finished at around 12:30pm, Ms Stratton and Mr Natsis lay down on some sofas in the lounge room to watch a movie. Ms Stratton lay down on a two seater sofa, with her head on an arm rest. Phoenix lay on top of Ms Stratton's right arm in the natural hollow between her body and the back rest of the sofa, with his head pillowed on her right shoulder. Mr Natsis lay on another two seater sofa in the lounge room.

5.5 At some point whilst watching the movie, both Ms Stratton and Phoenix fell asleep. It appears that during this period, it is likely that Mr Natsis self-administered one of the takeaway doses of methadone.

5.6 Ms Stratton woke up at around 4:20pm with a Phoenix still lying next to her. However, she noticed that Phoenix was limp, not breathing and unresponsive. Ms Stratton called for assistance from Mr Natsis, and they placed Phoenix in their car and commenced driving to Blacktown Hospital. Whilst en route, Ms Stratton attempted to provide expired air resuscitation to Phoenix.

5.7 Ms Stratton and Mr Natsis arrived at Blacktown Hospital at approximately 4:39pm. Phoenix was transferred to the care of medical and nursing staff, who continued resuscitation efforts. Despite these attempts, Phoenix could not be revived and was pronounced life extinct at 5:11pm.

6. What was the cause of Phoenix's death?

6.1 Phoenix was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Rebecca Irvine, forensic pathologist, on 1 and 2 April 2015. The examination revealed no significant findings apart from routine toxicological analysis identifying a 0.42 g/100mL concentration of methadone in leg blood, with a significantly higher (1.5 mg/L) concentration of methadone from a specimen of heart blood. Dr Irvine noted that this second concentration is likely to represent postmortem redistribution.

6.2 Dr Irvine noted that the blood concentration of methadone is within the reported fatal range for adults and that Phoenix had no medical condition to suggest significant opiate tolerance was present. Dr Irvine also noted that the toxic effects of methadone include sedation and suppression of respiratory efforts. In the autopsy report dated 2 June 2015, Dr Irvine opined that the cause of Phoenix death was methadone toxicity.

6.3 As part of the police investigation, an opinion was sought from John Farrar, a consultant forensic pharmacologist. In a report dated 3 June 2015, Mr Farrar opined that:

(a) any tolerance to methadone that Phoenix developed whilst in utero would have been diminished over the course of the neonatal withdrawal period and during continuation of methadone-free status; and

(b) whilst any tolerance to methadone that Phoenix developed as a consequence of being breastfed by Ms Stratton cannot be established, it would have diminished to insignificant levels after weaning.

6.4 Ultimately, Mr Farrar opined:

> It is highly improbable that Phoenix could have developed a tolerance to methadone to the extent that he would be capable of withstanding the quantity administered to him without deleterious effect.

6.5 In addition, testing was conducted on two hair segments taken from Phoenix which identified 7000 and 7300 pg methadone per mg, respectively. In addition, each of the hair segments were found to contain approximately 200 pg per mg of the major metabolite of methadone, 2-ethylidene-1,5-dementhyl-3,3-diphenylprrolidine (**EDPP**).

6.6 Heather Lindsay, a senior forensic scientist, provided a report indicating that the incorporation of drugs into hair is believed to occur through three main routes:

(a) diffusion from the bloodstream to the hair follicles and then incorporation into the hair and remaining as the hair continues to grow;

(b) diffusion from sweat and sebum secretions; and

(c) external contamination, particularly from drugs that are present as vapours or powders.

6.7 Ms Lindsay noted that in the case of a baby or young child, the incorporation of drugs into hair can also occur from breastfeeding by a mother who was using drugs and by being in close contact with an adult carer who is using drugs. In addition, as excessive sweating is one of the most frequent side-effects of methadone, it has been hypothesised that touching or combing of children's hair with sweaty hands, or sleeping together on a sweat -soaked pillow, can result in transfer of the drug and metabolite into the hair.

6.8 Ms Lindsay further expressed the following view:

> The detection of EDPP along with methadone is evidence of the metabolism of methadone before incorporation into hair. Therefore, the possible interpretations for the presence of the methadone [identified in Phoenix's case] are: intentional administration for sedation; accidental oral intake from contaminated utensils or access to methadone; external contamination by the sweat of carers using methadone. Pre-and post-mortem contamination of the hair with bodily fluids of the subject is yet another route of drug incorporation into the hair.

6.9 **Conclusions:** There is no reliable evidence that by 31 March 2015, Phoenix had developed any tolerance to methadone that would have significantly countered or reduced its toxic effects. Having regard to the fact that the quantity of methadone detected in Phoenix's postmortem blood sample was within the reported lethal range for adults, and to the opinions expressed by Dr Irvine and Mr Farrar, the cause of Phoenix's death was methadone toxicity.

7. Results of the subsequent police investigation

7.1 The police examination of the Seven Hills Property revealed most parts of the home to be in an unkempt state: clothing and other property items were found lying on the floor of the two bedrooms used for storage and dog faeces was seen on the floors. The kitchen sink was noted to be full of dirty plates, and the kitchen counters cluttered with discarded containers, food wrapping and partially consumed meals. The lounge room was also noted to be in an untidy state with discarded cigarette butts and other refuse on the floor.

7.2 In contrast, Phoenix's bedroom was noted to be very neat and clean. Unlike other parts of the house, no rubbish was found on the floor and Phoenix's cot was found to be neatly made, but did not appear to have been slept in.

7.3 Examination of the bathroom revealed an empty methadone container in the bath tub, with the lid securely attached and the label having been partially torn off. The container also showed evidence of having been wet. Six capped and sealed syringes were also located on top of a freestanding cabinet below the hand basin.

7.4 As police investigators considered that Mr Natsis consumed one of his two takeaway doses of methadone on 31 March 2015, one unused takeaway dose should have still been available. However, this could not be located inside the Seven Hills Property.

7.5 In addition, the Seven Hills property was searched by police and no evidence of any syringe, medical tubing or other drug paraphernalia was located in the bathroom. Further, whilst a syringe was located in a medicine cabinet, it was noted to be clean, with no residue. All other needles located within the Seven Hills property were noted to be capped and sealed.

8. How did Phoenix come to ingest the methadone?

8.1 Police investigators conducted an electronically recorded interview with both Ms Stratton and Mr Natsis on 9 April 2015. During the course of her interview, Ms Stratton suggested that at the time that Mr Natsis self-administered methadone on 31 March 2015, Phoenix got down from the sofa in the lounge room and somehow accessed the left over methadone in the syringe used by Mr Natsis. Following this, Ms Stratton suggested that Phoenix returned to the sofa and again lay down next to Ms Stratton.

8.2 In his interview, Mr Natsis asserted that he took one of the two takeaway doses of methadone on the morning of 31 March 2015 before lunch. Mr Natsis also denied and administering any methadone to Phoenix, or leaving any paraphernalia related to methadone administration lying around the Seven Hills property.

8.3 Ms Stratton's stepfather informed police that Phoenix had just started to walk around Christmas 2014, and that he could take a few steps and walk "*maybe a couple of metres before he sat down on his bum*". In addition, Phoenix was known to be able to "*reach up and grab stuff*", although he was not yet able to climb onto chairs and other furniture. Ms Stratton's stepfather noted that on the occasions that he visited the Seven Hills Property, he would have to pick up Phoenix to put Phoenix

on his lap, and that Ms Stratton would pick up Phoenix to put him on a chair. Ms Stratton's stepfather also expressed some doubt as to whether, by March 2015, Phoenix was able to feed himself as Ms Stratton and Mr Natsis "*would do most of the feeding*".

8.4 Investigating police sought an opinion from Professor Christine Norrie, a forensic clinician from the Child Protection Unit at The Children's Hospital at Westmead, who expressed the following views:

(a) A reasonably athletic child of Phoenix's age with no developmental delay would be capable of climbing onto a couch or chair without assistance;

(b) Phoenix would have been capable of sucking methadone from a syringe but would not be cognitively capable of knowing how to depress the plunger of a syringe even if he had seen others doing it;

(c) Due to its bitter taste, if Phoenix had obtained a quantity of methadone in his mouth, he would most probably spit it out if it had not been sweetened or was not contained in milk. However, Phoenix may have been used to being given small amounts of methadone to put him to sleep and, after a while, he may have not spat it out or refused to swallow it;

(d) Any methadone ingested by Phoenix on 31 March 2015 would not have been detectable in the two hair samples that were subsequently analysed.

8.5 **Conclusions:** The evidence establishes that on 31 March 2015 Phoenix most likely had the gross motor skills and cognitive capacity to climb down from his position on the sofa where he had been lying next to Ms Stratton and access a syringe containing a quantity of methadone. However, the expert evidence establishes that it is unlikely that Phoenix would have been able to depress the plunger of a syringe so as to self-administer a quantity of methadone contained within it. Further, even if Phoenix had been able to perform such actions, it is likely that the taste of the methadone would not have been tolerated by Phoenix. Having regard to these matters, it is most likely that on 31 March 2015 Phoenix did not act in the way suggested by Ms Stratton during her electronically recorded interview with police.

8.6 If the possibility of self-administration of methadone by Phoenix can be reasonably excluded, then the only possibility that remains is that Phoenix was administered a quantity of methadone by another person. Ms Stratton and Mr Natsis were the only other persons known to be in the Seven Hills property on 31 March 2015. The police officer in charge of the investigation, Detective Senior Sergeant Adam Wilson, gave evidence that in his opinion it is most likely that Phoenix was administered an amount of methadone in order to sedate him.

8.7 It should be noted that Ms Stratton died on 30 August 2016. As a consequence of this sad event, and despite extensive police investigation, no direct evidence has been identified as to how Phoenix may have been administered a quantity of methadone, and by whom. There is support for the opinion expressed by Detective Senior Sergeant Wilson from the detection of methadone in the two hair samples taken from Phoenix. As the available evidence excludes the possibility of self-administration of methadone by Phoenix, and there is no reliable evidence of external contamination from the sweat of Phoenix's carers, it is most likely that the detection of methadone in Phoenix's hair samples represents previous administration of methadone to Phoenix for sedation purposes.

8.8 Having regard to all of the above, it is most likely that Phoenix was administered a quantity of methadone by another person on 31 March 2015. There is no evidence to suggest that the methadone was administered with an intention to cause direct harm to Phoenix. Rather, the evidence suggests that the administration was consistent with a practice that had been adopted in the past, for methadone to be administered to Phoenix for sedation purposes. As the toxic effects of methadone cause sedation and suppress respiratory efforts, the administration of methadone to Phoenix had the unintended consequence of causing his death. The manner of Phoenix's death is, therefore, homicide.

9. Prescription of methadone to Mr Natsis

9.1 In February 2008, Mr Natsis came under the care of his general practitioner, Dr Thomas Bateman, for opiate addiction and was prescribed methadone. Mr Natsis' initial prescription was for 75mg methadone syrup daily with up to 4 takeaway doses per week but restricted to 2 takeaway doses at any one time. By March 2015, Mr Natsis' prescription had increased to 160mg methadone syrup with the same frequency of dosing.

9.2 Dr Bateman provided information to Mr Natsis regarding the importance of storing methadone securely and away from the children. This information was consistent with the NSW Health *Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment* (**Methadone Guidelines**) which existed at the time.

9.3 As to absolute contraindications to the provision of takeaway doses of methadone, the Methadone Guidelines relevantly provided that "*the highest priority is to be given to the safety of children residing in the patient's household*". In addition, the Methadone Guidelines also provided for the following:

> On initial assessment, at treatment review and when assessing eligibility for takeaway doses, it is important to consider the safety and welfare and well-being of any children within the patient's care. This may include a patient's own children, children living at the same residence, or children to whom the patient has access.
> […]
> In reviewing the appropriateness of takeaway doses for patients residing with children, the prescriber should always include dialogue with the dispenser (in most cases, a pharmacist). The dispenser may occasionally observe children with the patient and may be able to provide additional information as to the stability of the patient. The outcome of any review, including dialogue with the dispenser should be documented.

> […]
> Takeaway doses may be accidentally ingested by children or deliberately administered to them. If there are children in the patient's household, consideration needs to be given to the type of medication, the dose and the frequency of review of takeaway dosing.
> […]
> In households where there are children aged under 16 years, a detailed assessment should be undertaken, including **communication with other agencies who may be involved in patient management** [original emphasis].

9.4 During the relevant period, the methadone was dispensed to Mr Natsis at Xtreme Chemist in Toongabbie. Mr Natsis received supervised and takeaway doses of methadone in accordance with his prescription. The supervised dose was in a disposable plastic cup, which Mr Natsis would drink on the spot supervised. The takeaway doses of methadone were contained in PVC bottles with child resistant closure. As part of its usual practice, the dispensing pharmacist provided advice to every customer receiving methadone that "*whether they have children or not, that they should make sure that the customer knows the bottles are safe under lock and key away from the reach of children*".

9.5 **Conclusion:** The evidence establishes that, by virtue of Mr Natsis' history of illicit drug use, there was a clinical indication for him to be prescribed methadone as part of an opioid substitution program. The evidence also establishes that the Methadone Guidelines relevantly provided for a number of appropriate mechanisms for methadone to be prescribed and dispensed to adults living in the same household as children, and for methadone dispensed as takeaway doses to be stored safely within such households.

10. Involvement of the Department of Families and Community Services with Phoenix

10.1 The former Department of Families and Community Services (**FACS**) provided casework support to Ms Stratton and Phoenix up to 20 March 2014, when Phoenix's case was closed. From the time of closure until 10 April 2015, when FACS received a report that Phoenix had died on 31 March 2015, FACS did not receive any further reports about Phoenix's safety or well-being.

10.2 During the period that FACS provided casework support to Phoenix, caseworkers conducted a home visit at the Seven Hills Property on two occasions in February 2014. During these visits, FACS caseworker spoke to Mr Natsis about a number of relevant matters, including his history of drug use. Mr Natsis reported that he had previously used illicit drugs but had been abstinent for approximately nine years and that he was on the methadone program at the time. Mr Natsis also disclosed his prescribed dose of methadone.

10.3 Following these home visits, FACS made enquiries with the NSW Police Force regarding Mr Natsis' history of drug-related offences within the previous five years (of which there were nine) and completed a risk assessment in March 2014. This risk assessment noted the following: "*Caseworkers have not identified any concerns during home visit regarding [Mr Natsis]'s presentation*".

10.4 The FACS Alcohol and Other Drugs Practice Kit (**the Practice Kit**) was published in 2017. Ms Lisa Charet, Executive District Director, Western Sydney and Nepean Blue Mountains for the Department of Communities and Justice, explained that the Practice Kit "*contains links to research and fact*

sheets to assist caseworkers to recognise when alcohol and other drugs may be present, to better understand the risks to a child and to provide strategies to target intervention that is most appropriate for a family". Relevantly, Ms Charet explained that if the Practice Kit was available at the time of the original safety assessment of Phoenix conducted on 22 January 2014:

> …it may have assisted the caseworkers to look holistically at Ms Stratton and Mr Natsis' history of drug use, their current drug use, whether their involvement in the opioid treatment program was assisting them and the impact of all of this information on their ability to safely parent Phoenix.
>
> The [Practice Kit] encourages and empowers caseworkers to be ready for hard conversations with parents/carers factoring in issues like the known points of tension about ongoing drug use and irregular participation in treatment programs such as the opioid treatment program. The [Practice Kit] also prompts caseworkers to obtain further information to build a more complete picture of a child's home environment.

10.5 Relevantly, the Practice Kit also provides question prompts for caseworkers to discuss the safe storage of methadone with parents/carers and for the methods of storage and disposal to be identified. A document titled, "*Looking and listening for problematic AOD use*", contained within the Practice Kit lists specific targeted questions as to the current drug use treatment of a parent/carer and how drugs as part of such treatment are used and stored. In addition, another document titled, "*Alcohol and other drugs: safety assessment and safety planning*", provides the following information to caseworkers:

> **Methadone doses must be stored safely and must never be used to settle or sedate a child.** Ask parents where it is stored and how they settle and soothe their baby when they are distressed. Ask them what they do when their normal soothing techniques do not work. [original emphasis]

10.6 Further, the Practice Kit provides for caseworkers to bring a brochure titled, "*Advice for parents and carer on storing methadone, safe sleeping and settling babies*" to home visits, and to be used to discuss these issues with parents or carers. This brochure contains advice for methadone to be stored away from easily accessible locations and instead in a child-proof medicine cabinet or in a locked cupboard in a high location, and for methadone doses to not be consumed in front of children.

10.7 **Conclusions:** The evidence establishes that FACS was not providing casework support to Phoenix or Ms Stratton at the time of Phoenix's death. At the commencement of casework support being provided in January 2014, a number of enquiries were made by caseworkers to provide reassurance that Phoenix was living in a safe household. These enquiries included two home visits, enquiries with NSW Police as to the extent of Mr Natsis' history of drug use, and a risk assessment. There is no evidence to suggest that at the time these enquiries were made, the likelihood of methadone being administered to Phoenix could have been identified or predicted.

10.8 At the time of Phoenix's death, it is not known whether caseworkers were provided with the type of information and resources that is presently contained in the Alcohol and Other Drugs Practice Kit, which was published two years after Phoenix's death. Had such information and resources been available in 2014 and 2015 then it may have prompted appropriate questions being asked of Ms Stratton and Mr Natsis as to safe storage of methadone within their household, and the risks associated with unsafe storage. However, there is no evidence to suggest that even if such a conversation had occurred between caseworkers and Ms Stratton and Mr Natsis that this would have likely prevented the occurrence of the tragic events of 31 March 2015.

11. Findings

11.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Tina Xanthos, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Detective Senior Sergeant Wilson for his dedication in conducting a comprehensive police investigation and for compiling the initial brief of evidence.

11.2 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Phoenix Hemmings.

Date of death

Phoenix died on 31 March 2015.

Place of death

Phoenix died at Blacktown Hospital, Blacktown NSW 2148.

Cause of death

The cause of Phoenix's death is methadone toxicity.

Manner of death

It is most likely that Phoenix was administered a quantity of methadone by another person on 31 March 2015. There is no evidence to suggest that the methadone was administered with an intention to cause direct harm to Phoenix. Rather, the evidence suggests that the administration of methadone on this occasion was consistent with a practice that had been followed previously where methadone was administered to Phoenix for sedation purposes. The toxic effects of methadone administration to Phoenix had the unintended consequence of causing his death. The manner of Phoenix's death is, therefore, homicide.

11.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Phoenix's family and loved ones for their tragic and heartbreaking loss.

11.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
19 August 2022
Coroners Court of New South Wale