OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Melanie Kate BOYD**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 1807/06(0)
DELIVERED ON:	5 November 2008
DELIVERED AT:	Townsville
HEARING DATE(s):	8, 9 & 10 October 2008
FINDINGS OF:	Mr Brian Smith Coroner
CATCHWORDS:	CORONERS: Inquest – Death by drug toxicity, teenagers, youth party, consuming illicit and prescription drugs, excessive alcohol consumption, unsupervised, failure to call emergency services

REPRESENTATION:

Mr John Tate, Crown Law – appearing to assist the Coroner

DEATH INQUEST - Melanie Kate BOYD

CORONERS ACT 2003 PROVISIONS

The inquest into the death of Melanie took place over 3 days on 8th 9th and 10th of October, 2008.

Section 45 of the Corners Act 2003 sets out the mandatory findings to be made namely:

(1) Who the deceased person is, and
(2) How the person died, and
(3) When the person died, and
(4) Where the person died, and
(5) What caused the person to die.

Section 46 of the Coroners Act 2003 provides for comments to be made, whenever appropriate, that relate to:

(a) Public health or safety or
(b) Administration of justice or
(c) Ways to prevent deaths from happening in similar circumstances in the future

Section 48 of the Act relates to the Coroner giving information to the Director of Public Prosecutions, if he/she reasonably suspects a person has committed an indictable offence, or to the Chief Executive of the relevant Department, for any other offence.

At the same time however, Section 45 (5) provides, somewhat oddly, perhaps, that:

"The coroner must not include in the findings any statement that a person, is or may be:

(i) Guilty of an offence, or
(ii) Civilly liable for something

THE INVESTIGATION

From the point of view of the next of kin, I can understand that this inquest has been a long time coming. I apologize on behalf of the Court, for the lapse of time involved. I am sure that this inquest was intended to provide some form of real closure for Mr. Boyd and his family, and it is regrettable that more than 28 months has passed since Melanie died, and the circumstances surrounding her death were able to be aired in open court. I trust that if that was the aim of the family, that to some extent, it has been achieved, wholly or at least in part. I can not honestly account for the delay, except to state the circumstances necessitated a full and detailed investigation, an analysis of various drugs, and the involvement of lawyers for the some of the persons involved. The investigating police officer Detective Sergeant Smith also has advised that whilst involved in this matter, he was also involved in at least one other serious criminal investigation, that those time constraints meant there were unavoidable delays in the investigation of this death.

It is obvious notwithstanding delay, during the course of the investigation, a significant rapport was established between Detective Sergeant Smith and the Boyd family, in particular

Mr. Laurie Boyd. The comment by Mr. Boyd in his moving testimony is a testament to that fact. Those two gentlemen obviously have a considerable amount of mutual respect for each other, as a result of their contact since June 2006.

I commend officer Smith on the thoroughness of his investigation and inquiries, in relation to what was an unusual set of circumstances. It involved a number of teenagers, at a party, at which a number of juveniles (persons under the age of 17), partook of both illicit and legal prescription drugs, supplied by one of the juveniles, together with apparent excessive alcohol consumption, in an unsupervised environment at a residence, without the knowledge and consent of the owners of that property.

At the conclusion of his investigation, Detective Sgt. Smith had obvious concerns in relation to the question of criminal responsibility/liability of all the players in the events of that night and morning. He noted that he considers he exhausted all avenues in that respect, even to the extent of seeking advice from the office of the Director of Public Prosecutions. At the end of the day, the advice he received was that, in all of the circumstances, as revealed in the final report, that noting the age of the young people, their particular maturity and their knowledge or lack of knowledge, that the laying of any charges, including that of criminal negligence, was not deemed appropriate.

I consider the detailed accounts, such as they were able to recall, provided by the witnesses, both in their statements, and in their verbal testimonies to the court such, that nothing will be gained by my repeating them now. Those accounts are now part of the permanent record.

Suffice to record that what was clearly intended to be a joyful, exuberant celebration that night (the occasion being the end of that semester for the four sixteen year old students) turned out to be a tragedy, in every sense of that word, which I have no doubt will stay with them for the remainder of their lives, with the loss of life of Melanie.

In an attempt to appear "cool", one of their number has supplied drugs to three of the others. Initially an unknown white powder, (she told them it was "speed") was snorted through the nose by three of them. No significant effect was felt. Shortly thereafter, the same young person, accessed two types of prescription drugs belonging to her parents. The drugs were more or less divided into three equal lots. Again three of the four girls then present, entirely without persuasion or encouragement, and without reference even to any warning information on the labels on the packets of the medication, proceeded to wash them down with various amounts of rum and coca-cola. Even though two of the girls suffered some serious consequences, as evidenced by the fits or seizures, unbelievably nothing ultimately was done, to contact the ambulance service, or any other responsible adult, until the next morning, when it was far far too late. It is ironic that Melanie, who was not observed to suffer any severe effects, and was not seen by any person that night, to suffer any seizure, was the one who reacted most sensibly and responsibly. Her initial immediate response to seeing the others fit, was to seek ambulance assistance, but that did not happen - with the call not being completed.

Remarkably also, the party, and the party atmosphere continued more or less unabated, even though, as the record reveals, there was some monitoring of the two girls who had shown obvious signs of severe complications, from time to time. Ultimately, as the

celebrations drew to an end, the other persons then present including, two eighteen year old males, and a nineteen year old female, retired to bed, in the early hours of the next day, oblivious to the scenario unfolding in the house in which they were staying. Some of the events as related to the court were sketchy and vague in some respects, and even now it is uncertain that all that took place that night and morning has been fully and accurately put before the Court.

It is incredible that the two students who were not incapacitated in the early part of the evening, (one of which was of course Melanie) did not comprehend the seriousness of the seizures suffered by their friends - the potential for brain damage or possibly death. Perhaps even more astounding is that the older teenagers, the young adults, Matthew Aubrey and Zohe Horne, and Kelly Neville chose to "go along" with the joint decision apparently made - not to call am ambulance. Without doubt, each of those persons, in any objective and reasonable assessment of the situation, demonstrated extremely poor judgment, in what was in reality, a life and death situation. The reason offered by one young adult, for not taking charge of the situation-

"It was not my party, not my house, not my call"

was hardly a reasonable or acceptable explanation.

It transpires now, that if those present could relive the events, with the extra knowledge, maturity and some further insight, different decisions would almost certainly be made, and the death of Melanie would almost certainly have not occurred.

It is indisputable, that the decision made not to complete the initial phone call, and then later not to call an ambulance, until such a late point in time, was based upon the concerns that the young people had that by doing so, that either the owners of the house at which they were partying, or their daughter, who had supplied the drugs, would be in significant trouble with the law. That is because the triple O emergency number was dialled, and there was an assumption, (perhaps an entirely reasonable one) that the police service would be involved as a matter of course. It is now known that decision was based on an incorrect assumption.

As I believe counsel may have commented, the circumstances of this case are a sad reflection on each and every person present at that party, whether they actually observed the taking of the drugs or not. Without doubt, it became obvious to the late arrivals, (the older teenagers) just what had taken place, although some of the witnesses were reluctant to be forthright about this fact. None of them according to their evidence recognized the danger signs, heard any warning bells, in relation to the potentially life threatening behaviour in which the young girls had indulged. The witnesses opinion and belief that the taking of prescription drugs, in those quantities, is somehow safer, and less dangerous than street drugs of which they had some knowledge, is difficult to comprehend. No one was prepared to be a leader, and to take charge, and to act responsibly, in relation to the crisis with which they were confronted. It is also correct to claim the traditional Australian practice of looking out for your mate or friend, when in sick, or in jeopardy of some kind, was essentially ignored, for entirely inappropriate considerations. What was needed that night, in the light of what had taken place, was simply a little intelligence - indeed some plain, old-

fashioned common sense. Cool heads were notably absent that night, attributable, without doubt, to a large extent, to the drug taking and alcohol consumption, although some were in a worse state than others.

I now make the formal findings required by the Coroners Act 2003.

FINDINGS

NAME OF THE DECEASED: MELANIE KATE BOYD

DATE OF DEATH: 23RD JUNE 2006

CAUSE OF DEATH: ASPIRATION OF GASTRIC CONTENTS
DUE TO
DRUG TOXICITY

WHERE THE DEATH OCCURRED: PALLARENDA VIA TOWNSVILLE

HOW THE DEATH OCCURRED:

Melanie has smoked a small amount of cannabis sativa, with three of her friends, some unknown white powder, by snorting through her nose, and then over time, a number of small round blue pills and some larger orange pills, (prescription medication) and washed them down with rum and coke. Two of her friends became very ill, before their status appeared to the others, to stabilize.

An initial attempt to phone an ambulance, was discontinued, as it was thought the police would be automatically involved, which would involve those present, and perhaps the owners of the property, being in conflict with the law.

The only apparent ill-effects Melanie suffered was that she became extremely drowsy, and was put to bed.

She did awake, on two occasions but later returned to the bed. This may have given her friends a false sense of security in relation to her welfare. The concern by her friends was directed more to the two who had suffered the seizures.

Some monitoring of her condition did occur, but not until the next morning and she was thought to be just "sleeping off" the effects of the celebrations, and snoring heavily, as the night before.

At some time during the night she has either suffered a fit herself and/or was sick and/or vomited.

Late on the morning of 23/6/06, when real concerns were expressed for her welfare, Ambulance officers were finally called, but attempts to revive her were unsuccessful. The account by Professor Williams is essentially that owing to the effects of the drugs, particularly, the drugs Codeine, Tramadol and Promethazine (a central nervous system depressant) combined with alcohol, she suffered from impairment of her reflexes, due to her brain not functioning properly. This then resulted in her death due to the cause nominated.

GENERAL COMMENTS:

It is difficult to formulate intelligent recommendations in this matter. I have attempted to gain access to other similar cases by accessing the National Coronial Information System (NCIS) but that indicated no deaths at all in similar circumstances in Australia, from January 2000 to June 2008. That surprises me bearing in mind some of the evidence as to the possible existence of the so-called "Pharm Parties" in and around Townsville. The lack of previous incidents may simply be an indication and reflection of the obvious inherent danger in indulging in such practices.

I note the Townsville Bulletin of 25/10/08, and the comment and article entitled:

"PARTY HARD - PARTY SAFE"

TIPS ON THROWING A HASSLE FREE PARTY

What followed was a ten-point plan. That plan certainly goes a long way to ensuring that an incident like this would not occur, if even some of those suggestions, are taken up by the party organizers. For example, I note tips, 1, 2. and 3:

1. Monitoring the party
2. Suitable supervision of the party

3. If problems develop, notify the police, BEFORE things get out of control

(To that I would of course had QATB for someone being ill or showing serious of stress or injury)

4. Registering the party with the Police Service

I also note that **PARTY SAFE PACKS** are apparently available from all police stations within the Townville Police District. The Police Service is to be commended on the initiatives they have taken in this respect.

I realize that his particular party was specifically organized, as that address, because:

(1) the owners of the residence were absent.
(2) the intention of the young girls was to engage in some unlawful activities - and to engage in the consumption of alcohol.
(3) at that address, they could indulge themselves without fear of detection or interruption.

In essence, that was a recipe for the worst possible outcome, and ultimately, within 24 hours, that turned out to be the case, for all those involved, and for their friends and families. As Mr. Boyd has stated, the events of that night could so easily have resulted in the loss of three lives.

The behaviour of the students, in ingesting excessive amounts of unknown prescription drugs, with liberal quantities of alcohol, was dangerous and foolhardy in the extreme.

RECOMMENDATIONS:

Any recommendations I make must be reasonable and intelligible.

I have consulted with the Queensland Ambulance Service in relation to this matter, and obtained a copy of some current literature published by that service for the information of the public. In May 2007, as a result of concern in relation to the need to adequately inform the public whether the ambulance service routinely advised the police service of emergency situations, a special electronic flyer was developed, to make it clear what the position is, and placed on the QAS web page. To that extent then, there is more information available now, than there was in 2006. It is difficult to see how the contents of that flyer can be made more easily understood. However, it may be that greater publicity should be given to the information contained therein, and that it could be distributed more widely, in the Queensland community in the form of a hard copy.

Pursuant to the Coroners Act 2003, Section 46, I make the following comments:

I recommend:

(a) That the Minister for Education supply to all secondary schools in Queensland details of these findings in relation to the death of Melanie, for incorporation into their Drug Education Programme as an important case study that young people may

be able to relate to, with strong emphasis being given to the fact that her death was directly linked to the inordinate delay in the calling of assistance from the ambulance service, owing to a belief by the students, that police authorities would be contacted, which is not necessarily the case. (N.B. See (c) below.)

(b) That the Minister for Education advise all secondary schools in Queensland to update their current Drug Education Programmes in relation to prescription drugs in the light of this death, and direct them to highlight the fact that some students may hold the erroneous belief that prescription drugs are less dangerous than street drugs.

(c) That the Minister for Education advise all secondary schools in Queensland to update their current Drug Education Programmes and highlight the important disclosure that when an emergency triple O call is responded to by the ambulance service to treat an injured or sick person, (including in relation to drug taking) that does not automatically mean that the ambulance officers have to report the incident to the Police Service. (The Queensland Ambulance Service is bound by Section 49 of the Ambulance Service Act 1991, NOT to provide information that would identify a person who has received ambulance treatment and/or transport. The Queensland Ambulance Service does not notify the Queensland Police Service when they respond to an emergency when illicit drugs are involved except when:
    1. the paramedics physical safety or the physical safety of others are at risk
    2. a death has occurred at the scene
    3. paramedics respond to a person who has suffered a violent injury such as a stabbing or shooting.)

(d) That the Minister for Education advise all secondary schools in Queensland to consider implementing for students particularly in Grades 9,10,11, and 12, comprehensive first aid courses to ensure that they have a clear practical understanding of how the human body works, and the potential serious consequences of passing out, or going to sleep, after excessive drug and/or alcohol consumption, which can lead to inhalation of stomach contents, and ultimate death.

(e) That the Commissioner of the Queensland Ambulance Service consider, if he is not already doing so, providing copies of the flyer entitled **"Calling for an ambulance when illicit drugs have been taken"** to various sections of the community, and in particular to all secondary schools in Queensland on a regular basis, to ensure that important message is distributed as widely as possible.

Those are my recommendations.

This inquest is now closed.

(B.L.Smith)
CORONER
TOWNSVILLE
5 / 11 /2008