Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Stephen Raymond Carey, Coroner, having investigated the death of Geoffrey Ross Sydney Thompson

Find That:

(a) The identity of the deceased in this matter is Geoffrey Ross Sydney Thompson (“Mr Thompson”);
(b) Mr Thompson died in the circumstances described in this finding;
(c) Mr Thompson died on 30 March 2014 at Wolstenholme Drive, Sorell;
(d) Mr Thompson died as a result of mixed prescription drug and ethanol toxicity (promethazine, citalopram and ethanol);
(e) Mr Thompson was born in Tasmania on 24 June 1965 and was aged 48 years at the date of death;
(f) Mr Thompson was a married man whose occupation was spray painter; and
(g) No other person contributed to Mr Thompson’s death.

Circumstances Surrounding the Death:

Mr Thompson had, for many years, suffered the effects of apparent allergic reactions. This would usually demonstrate itself by initially his feet becoming itchy and his body would become hot and he would break out in lumps. He received medical advice that he was allergic to dust mites and was advised to take antihistamine medication each day and from that time on he would take over-the-counter medication Telfast together with prescribed Phenergan (Promethazine).

Mr Thompson was a very sociable person having a wide range of friends and associates and in recreational times he would consume significant amounts of alcohol. The drug Promethazine comes with a warning that users ought to avoid the
consumption of alcohol given that both the drug and alcohol are central nervous system depressants.

Mr Thompson was a keen golfer, being a member of the Pittwater and Colebrook Golf Clubs and he played golf every Saturday, randomly on Sundays and every public holiday. On Saturday 29 March 2014 Mr Thompson, together with a group of male friends, organised a bus in which they travelled together to Symmons Plains to watch motor sports during which time alcohol was consumed. Mr Thompson returned to the home of a friend, Mr Harry Oxley, and was collected by his wife, Leanne, at approximately 10:00pm and taken to their home.

The next morning, at approximately 6:45am (Sunday, 30 March 2014), Mr Oxley collected Mr Thompson from his home in Mr Thompson’s car which had been left at Mr Oxley’s house the previous evening. Messrs Thompson, Oxley and perhaps one other then played a round of golf at the Pittwater Golf Club, teeing off at approximately 7:30am. They played 18 holes concluding by approximately 11:30am. During the course of playing that round of golf, alcohol was consumed by the group. They then remained at the Club House until approximately 1:00pm consuming further alcohol. After leaving the Golf Club they travelled to the Midway Point Tavern, continued to consume alcohol when at approximately 3:30pm Mr Thompson left after receiving a telephone call from his wife that she was coming to collect him. Apparently, however, Mr Thompson drove himself home, arriving at some time estimated prior to 4:00pm.

Mrs Leanne Thompson noted that he was significantly affected by alcohol at that time and she expressed her disapproval of the fact that he had driven his motor vehicle whilst affected by alcohol. Mrs Thompson left the home for a period of time returning at around 4:30pm when she was advised by Mr Thompson that his rash had appeared. It was not unusual for this rash to flare after he had consumed alcohol. He was handed a packet of 10mg Pherergen tablets by his wife. She believes there was 8 in the pack and he consumed the pack in its entirety. Mrs Thompson comments that she did not keep track of how much medication he consumed in relation to his allergic reaction and she did not believe that Mr Thompson took any care as to the amount of medication he was consuming.

Mr Thompson then went out of the house to a shed in the backyard for a period of time. When he returned he is described as being fine, walking, standing and talking. He had a snack and then advised his wife he was going to bed. Later that evening Mrs Thompson went to the bedroom and noted her husband lying on the bed, she tried to rouse him and noted that he was not breathing. Emergency services were contacted with police arriving at 9:10pm. The attending police moved Mr Thompson off the bed and on to the floor and commenced CPR. Ambulance officers arrived shortly thereafter and, assisted by the police officers, resuscitation endeavours continued for approximately 40 minutes. These endeavours were unsuccessful and were ceased at approximately 9:45pm.

A post-mortem determined no anatomical cause for death, however toxicology results upon blood samples taken of Mr Thompson indicate the cause of death being
a mixed prescription drug and ethanol toxicity (promethazine, citalopram and ethanol). Particular note was taken of the fact that due to reports that Mr Thompson suffered from an undiagnosed medical condition that caused episodic rash and swelling of his face and head that evolved into anaphylaxis for which he carried an adrenaline auto-injector, therefore the post-mortem examination considered that possibility. However, the examination did not find any sign of gross stigmata of anaphylaxis. Specifically, the lungs were not hyper-expanded and there was no oedema or hyperaemia of the epiglottis or upper airways that appeared patent. The serum tryptase was within normal limits, essentially excluding anaphylaxis as a cause of death.

The toxicology results showed the presence of promethazine in the reported “toxic range” however as this drug is known to undergo a post-mortem redistribution in the body such result is interpreted with caution. The forensic pathologist comments as to the toxicology report as follows:

“These results are interpreted by me to suggest that the combined effects of these prescription drugs and ethanol have caused central nervous system depression followed by respiratory depression and arrest resulting in death.”

Comments and Recommendations:

I have decided not to hold a public inquest hearing into this death because my investigations have sufficiently disclosed the identity of Mr Thompson, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the Births, Deaths and Marriages Registration Act 1999. I do not consider that the holding of a public inquest hearing would elicit any significant information further to that disclosed by the investigations conducted by me.

This tragic event serves to highlight that all medication, including prescribed medication, is potentially harmful if not taken in the directed dosage and mindful of the warnings and recommendations associated with the medication. Mr Thompson apparently had a cavalier attitude to the amount of medication he consumed and also as to the risks associated with alcohol use (especially at a high level), in conjunction with taking Phenergan (Promethazine). Unfortunately this careless attitude has resulted in his death.

I wish to convey my sincere condolences to Mr Thompson’s family.

Dated: 18 March 2015 at Hobart in the state of Tasmania.

Stephen Raymond Carey
CORONER