



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Lauren Elizabeth Bunn

Find, pursuant to Section 28(1) of the *Coroners Act 1995*, that

- a) The identity of the deceased is Lauren Elizabeth Bunn;
- b) Ms Bunn died as the result of the ingestion by her of a quantity of drugs, an action undertaken by her voluntarily, alone and with the express intention of ending her own life;
- c) The cause of Ms Bunn's death was mixed drug toxicity; and
- d) Ms Bunn died on 13 October 2016 at 25 Donald Street Branxholm, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Bunn's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; results of toxicological analysis of samples taken at autopsy; relevant police reports and affidavits; witness affidavits; medical records and reports; and forensic and photographic evidence.

Ms Bunn had a lengthy history of serious mental illness. In the months leading up to her death she had several documented incidents of suicidal ideation and/or attempts which led to periods of treatment as a psychiatric inpatient. In addition, and most relevantly, Tasmania Police records indicate that officers attended at her home on 2 January, 18 January, 22 January, 18 May, 3 August, 6 August and 5 September 2016 in response to concerns as to her welfare, particularly in relation to self-harm, threats of suicide and actual suicide attempts.

She was treated with medication, although appears to have been poor in compliance with her medication regime. In addition, Ms Bunn was supported by her general practitioner and the area Crisis Assessment Team as well as by referral to a sexual health specialist.

In the early hours of Thursday 13 October 2016, Ms Bunn called a counsellor with the Rural Alive and Well service. She told the counsellor she had drunk 2 litres of red wine and taken all her prescription medication. Ms Bunn also told the counsellor she had access to other medication which belonged to her former partner. At the end of the conversation the counsellor was assured by Ms Bunn that she was “okay” and would go straight to bed.

About 15 minutes later Ms Bunn called the counsellor again. The counsellor noticed Ms Bunn was slurring her words. Ms Bunn told the counsellor that she had taken more medication. She told the counsellor that she [Ms Bunn] did not wish to be alone when she died.

Very concerned for her welfare, the counsellor contacted the Police Radio Dispatch Service (RDS) at 1.50am. The RDS operator accessed information about Ms Bunn in the Tasmania Police information system and called out the on-call officers for the area. Two officers were required to attend the incident. The officers met at Scottsdale Station and then travelled to Branxholm together arriving at Ms Bunn’s home at 2.45am. Unable to make contact with Ms Bunn the officers forced their way into her home where they found her on the lounge room floor on her stomach convulsing. She was described as thrashing uncontrollably as well as groaning. Mucus and saliva were observed coming from her mouth. The officers immediately contacted RDS and requested an ambulance to attend. That request was made at 2.58am.

The officers attempted to place Ms Bunn into the recovery position but as she was fitting and thrashing it proved impossible to maintain her in that position. Furniture was moved in the attempt to make the area as safe as possible.

Ambulance personnel arrived at the scene at 3.29am. As Ms Bunn was being moved through the hallway towards the front door (on a backboard which could be slid along the floor) she began to arrest. A defibrillator was used and CPR commenced and continued. Adrenaline was administered. After 20 minutes of attempted resuscitation Ms Bunn was pronounced dead by a paramedic.

An investigation in relation to Ms Bunn’s death commenced at the scene. The house was searched and a number of empty blister packets were located. Criminal Investigation Branch and Forensic Service officers attended the scene and conducted enquiries. Ms Bunn’s body was removed from the scene and transported to the

mortuary at the Launceston General Hospital where an autopsy was carried out. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. That analysis revealed significant quantities of various prescription drugs within toxic and fatal ranges.

The pathologist who conducted the autopsy expressed the opinion that the cause of Ms Bunn's death was multidrug toxicity. I accept this opinion.

I am satisfied on the evidence that there are no suspicious circumstances surrounding Ms Bunn's death. I am satisfied that she acted alone and that no other person was involved in her death.

As part of the investigation into Ms Bunn's death it was necessary to consider the response of both the police and ambulance services. The decision by the RDS operator to dispatch two police officers to the incident at Ms Bunn's home was, in my view, entirely reasonable. The time taken by police to respond to Ms Bunn's home in light of the isolated area in which it was located and the fact two officers were required to attend was in my view entirely reasonable. However, the fact that the RDS operator did not also call for an ambulance at the same time as police officers were dispatched was unfortunate. The operator had been told by a counsellor that it was her belief that Ms Bunn had taken an overdose of pills and intended taking more medication. She described to the RDS operator Ms Bunn slurring her words and sounding slow in her responses. The information was from an entirely credible source. The information, coupled with Ms Bunn's previous history recorded in Tasmania Police information systems, to which the RDS operator had full access, ought to have alerted him to the need to dispatch an ambulance to the scene as soon as possible. It was not necessary to await for the information to be confirmed by attending police.

It is of course possible that Tasmania Ambulance Service, even if contacted, may have elected to wait for police to attend the scene given Ms Bunn's known history. Even if they had, it is obvious that paramedics would have been in a position to have commenced treatment of Ms Bunn considerably earlier than in fact occurred. At the risk of repetition police did not ask for an ambulance to be dispatched until 2.58am (10 or so minutes after their arrival) and the ambulance did not arrive for over half an hour after that. The delay was unnecessary. The applicable procedures within RDS seem only to deal with information from Lifeline, but no other similar services, such as Rural Alive

and Well. It appears that this gap in policies and procedures contributed to the delay in the dispatching of the ambulance. It needs to be reviewed.

Comments and Recommendations

In the circumstances of Ms Bunn's death I consider it appropriate to **recommend** that Tasmania Police review the applicable RDS policies and procedures dealing with the circumstances in which an ambulance is to be dispatched to reported suicide attempts.

I convey my sincere condolences to the family and loved ones of Ms Bunn.

Dated 5 March 2018 at Hobart in Tasmania.

Simon Cooper
Coroner