



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



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 Ms D

Find that:

- a) The identity of the deceased is Ms D;
- b) Ms D died in the circumstances set out further in this finding;
- c) Ms D died as a result of mixed drug toxicity (amitriptyline, chlorpheniramine, diazepam, codeine) complicated by enlarged biventricular heart hypertrophy;
- d) Ms D died on 29 April 2014 in Northern Tasmania;
- e) Ms D was born in the United States of America and was aged 51 years at the time of her death; she was a single woman in receipt of a disability pension;
- f) No person contributed to the cause of Ms D's death.

Circumstances surrounding the death:

After completing her high school education Ms D commenced study at the University of Tasmania, however due to health issues she was unable to successfully complete the early stage of her course. She then moved to Melbourne where her father was living at the time and worked in fast food outlets as a manager. She suffered an injury to her back in the course of that employment. This is believed to have been in approximately 1998 and as a result of this she was unable to continue her work and received Commonwealth disability payments. In approximately 2005 she moved to her residence in northern Tasmania and led a rather solitary life although she remained close to her parents seeing them almost every day. She engaged in tutoring senior high school students in maths and science and also assisted in the care of her mother, especially in driving her to places where she needed to go. She ran a market stall each Sunday with a friend where they sold home made soaps, jewellery and shells. Her friend reports that Ms D did not appear to be depressed, however, she reported not being happy as she was lonely and had difficulty in making friends. Family and friends report that Mrs D on occasions appeared to be "spaced out", this was thought to be as a result of the analgesic medication that she consumed in respect of her back injury. She is also reported to have used significant over-the-counter antihistamine-style medication as she thought she was allergic to many things, even dust. Ms D was a hoarder and her house was full of items. In the weeks leading up to her death Ms D was reported to

have complained more frequently to her mother and father about headaches that she suffered. She was also noted by family to be more vague and distant than usual, she was sleeping past appointments that she would not normally miss. Members of her family and also her treating general practitioner had counselled Ms D to reduce the amount of medication that she was taking, especially the opiate-based analgesia due to the risks of such long-term use.

On the night before her death, Ms D's father called and spoke to her about daily activities, and she appeared to be fine and well at this time. At approximately 1.00am the following morning, Ms D called Ms C who was known to Ms D as she was the carer of Ms D's mother. The conversation lasted approximately 10 minutes during which time there was some mention of Ms D having ants all over her body. There was discussion about a need for her to get out of the room and that the room would need to be fumigated. The existence of ants in the house had been noted previously, possibly because of the rubbish hoarded by Ms D. In any event, throughout this conversation Ms C thought that Ms D sounded happy and lucid and she did not believe there was any note of concern, save for the oddness of the phone call being out of character and at an unusual time.

During the course of that day, Ms D's father tried to make contact with her but was unsuccessful. At first he was not concerned by this behaviour as his daughter regularly failed to answer her phone. By the late afternoon his attempts to make contact had increased in frequency with no avail. Her father then attended Ms D's address where he located the doors open but the screen doors locked. His daughter's vehicle was present in the driveway of the residence.

Mr D tried to call out to his daughter but still could not raise her. He contacted police for assistance at 5.20pm.

Police attended and spoke to Mr D who was still in attendance at the residence. He was physically disabled and unable to make entry to the house himself. Police tried to raise Ms D but to no avail before they gained access by unlocking the rear screen door via an open nearby window. Upon entry police located Ms D lying on her bed, face up, fully clothed. Her body showed no signs of trauma but was obviously deceased.

Her body was covered in ants that had started to consume her flesh, leaving wounds over much of her body. This was especially evident on the deceased's feet, stomach and underarms.

The television in the bedroom was on but "paused" and there appeared to be a freshly consumed McDonalds meal near the body. The house was in a poor state of cleanliness.

There was no obvious sign of prescription medication identified in the initial examination of the premises by police, however antihistamine-type medication was located. A brother of Ms D, whilst cleaning her residence after her death, located a large supply of medication including endone, panadeine forte and endep.

It was noted that six days prior to her death police had attended a similar incident at Ms D's residence. Her father was again unable to contact her by telephone. On this occasion he attended at her residence, could not raise her and contacted police. Upon arrival police located Ms D asleep in bed, she was not easily roused and ambulance attended. On that

occasion Ms D, after being aroused, declined to attend the Launceston General Hospital for further assessment.

Unfortunately Ms D appears to have developed a need to consume an excessive amount of opiate-based medication and also antihistamine medication, the opiate medication in respect of her complaint of back pain and the antihistamine medication to address allergies she believed she suffered from, but also due to the drowsy affect of them to assist her sleep. The toxicology testing of post mortem blood identified amitriptyline (endep) at a level within the reported toxic range, chlorpheniramine at a level greater than therapeutic with diazepam at a therapeutic level and codeine at a therapeutic level. All of these medications have a central nervous system depressive effect which may potentially include symptoms of sleepiness and uncoordination, staggering, blurred vision, impaired thinking, slow reflexes and breathing, decreased heart rate, and loss of consciousness possibly leading to coma or death. These effects would be more significant with Ms D who was identified at post mortem to be suffering an enlarged biventricular heart hypertrophy. It is apparent that her death was caused by a combination of both.

Although Ms D may not have been happy with her life, she was positively engaging with family and close friends and there was no indication of any intent to self harm. I find that this tragic outcome was as a result of accident.

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 Ms D, the date, place, cause of death, relevant circumstances concerning how her death occurred and the particulars needed to register her 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.

Before I conclude this matter, I wish to convey my sincere condolences to the family of Ms D.

This matter is now concluded.

Dated: 6th April 2015 at Hobart in the state of Tasmania.

Stephen Raymond Carey
CORONER