MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006 (Rule 11)

I, Duncan Fairley, Coroner, having investigated the death of Justin Blade Stewart

Find that:

a) The identity of the deceased is Justin Blade Stewart;
b) Mr Stewart died in the circumstances set out below;
c) Mr Stewart died as a result of mixed drug toxicity;
d) Mr Stewart died between 5 and 6 March 2016 at 6 Hazelwood Parade, Ravenswood in Tasmania;
e) Mr Stewart was born in Dampier, Western Australia on 15 July 1979 and was aged 36 years;
f) Mr Stewart was in a de facto relationship and was employed as a shed hand and wool presser at the date of his death.

Background:

Justin Blade Stewart was born in Dampier, Western Australia to Gregory and Dimity Stewart on 15 July 1979. Mr Stewart was the middle child of 7 siblings. When he was 13 years of age Mr Stewart's mother observed that he commenced using cannabis. It was also around this time that Mrs Stewart recalls her son began exhibiting the behaviours which would later lead to a diagnosis of schizophrenia.

During his teens Mr Stewart spent a period of time at the Ionia Station near Carnarvon, Western Australia as part of a juvenile justice system program. It was at this juncture he commenced his career as a shearer. He worked on various stations in Western Australia and New South Wales. On a number of occasions Mr Stewart was incarcerated for dishonesty-related offending in addition to spending periods admitted to psychiatric facilities. Mr Stewart moved to Tasmania in 2003 and commenced a relationship with Robyn Elizabeth Graham shortly thereafter.

Mr Stewart served a further brief sentence of imprisonment for aggravated burglary during 2008. Subsequently, Ms Graham observed that her partner was able to bring his mental illness under control with the assistance of a medication regime which included fortnightly injections of an antipsychotic agent. Mr Stewart's mental health was monitored through the Launceston General Hospital. In her statement to coronial investigators, Ms Graham confirmed that Mr Stewart was also a daily user of cannabis.

During the period leading up to his death, Mr Stewart continued to work as a shed hand and wool presser, a position he had maintained since May 2004.

Circumstances Surrounding the Death:

On 5 March 2016 Mr Stewart spent much of the day sleeping as he was feeling unwell due to a chest infection. Ms Graham was also unwell and she spent most of the day sleeping in her bedroom. Both Mr Stewart and Ms Graham consumed cannabis through a smoking device during the day.

Ms Graham woke at 3.00am on 6 March 2016 and discovered her partner asleep in a chair in the lounge room. She believed Mr Stewart was cold so she covered him with a blanket before returning to bed. At approximately 9:20am Ms Graham went into the lounge room to check on Mr Stewart and discovered him still seated in the chair with his eyes open. Ms Graham telephone for emergency services who attended promptly. It was immediately apparent that Mr Stewart had been deceased for some time. No attempt was made at resuscitation.

Mr Stewart's body was removed from the Ravenswood residence and taken by mortuary ambulance to the Launceston General Hospital. An autopsy was performed by Dr Terry Brain, pathologist, on 7 March 2016. Dr Brain was unable to find any sign of significant external trauma nor any obvious cause of death. Further investigations included toxicological examination which revealed, in addition to delta-9-tetrahydrocannabinol (the major psychoactive constituent of cannabis), Oxazepam and Quetiapine, an atypical antipsychotic drug, in greater than theraputic concentrations. Temazepam and Alprazolam were also detected, however, within the theraputic range.

All of the prescribed medications detected are known central nervous system (CNS) depressants. Further, the concomitant use of CNS depressant agents increases the risk of significant CNS depression occurring. The physiological depression of the CNS can result in a range of symptoms including, amongst others, slowed reflexes and breathing, decreased heart rate and loss of consciousness possibly leading to coma or death. The pathologist expressed the opinion that Mr Stewart's death was caused by mixed drug toxicity. I accept Dr Brain's opinion.

I am satisfied that Mr Stewart died in the circumstances set out in this finding. There is no suggestion that Mr Stewart ingested the mixture of CNS depressant agents identified with the intention of ending his life.

Comments and Recommendations:

In the circumstances there is no need for me to make any further comment or recommendations.

In concluding, I convey my sincere condolences to the family and friends of Mr Stewart.

Dated: 29 Janurary 2018 at Launceston Coroners Court in the State of Tasmania.

Duncan Fairley
Coroner