



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of David John Hinley

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

- a) The identity of the deceased is David John Hinley;
- a) Mr Hinley died in the circumstances set out further in this finding;
- b) The cause of death was mixed prescription drug toxicity (codeine, paracetamol, mirtazapine, promethazine and diazepam); and
- c) Mr Hinley died between 13 and 14 March 2017 at Lenah Valley, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Hinley's death, such evidence including:

- The Police Report of Death for the Coroner;
- Autopsy report of the forensic pathologist;
- Toxicological evidence regarding the results of Mr Hinley's post-mortem blood sample;
- Affidavit of Elizabeth Hinley, Mr Hinley's wife and senior next of kin;
- Medical records of Dr Alex Sutherland, Mr Hinley's general practitioner;
- Identification and life extinct affidavits;
- Affidavits of four police officers attending the scene of death, including a Forensic Services officer who examined and photographed the scene;
- Information from Mr Hinley's daughter, Amanda Hinley;
- Information from Pharmaceutical Services Branch regarding medication taken by Mr Hinley; and
- Report from Dr Anthony Bell, coronial medical consultant, regarding Mr Hinley's medication and treatment.

David John Hinley was born on 8 March 1943 and was aged 74 years at the time of his death. He had been married for 52 years to his wife, Elizabeth Colleen Hinley. Mr and Mrs Hinley

have two adult children. Mr Hinley was retired at the time of his death and had previously worked in management at Forestry Tasmania.

Medical records for Mr Hinley reveal that he had numerous medical conditions, including cerebellar ataxia (a degenerative disease of the part of the brain which coordinates movement), chronic obstructive pulmonary disease, osteoarthritis, chronic back pain, hypertension, asthma, diabetes, obesity, anxiety and depression. Mr Hinley was under the regular care of general practitioner, Dr Alex Sutherland, who prescribed an extensive list of medication for his diagnosed ailments. As a result of his cerebellar ataxia, Mr Hinley was required to mobilise with a four-wheeled walker.

On 23 January 2017, Mr Hinley attended a consultation with Dr Sutherland as he was experiencing a “situational crisis”. He told Dr Sutherland that he had run out of “panic pills” as he had used 100 in 20 days. It is unclear which medication he was referring to, however, Dr Sutherland strongly advised him to remain at three per day. Dr Sutherland had a lengthy discussion with Mr Hinley at that time and referred him for psychiatric review with Dr Milford McArthur.

On 1 March 2017, Mr Hinley attended a consultation with Dr Sutherland where they discussed Mr Hinley’s anxiety and depression as well as testicular pain and postural hypotension. Mr Hinley’s medication was reviewed and changes were made to the dosage of one of his medications. He was scheduled to return for review in two weeks.

On Monday 13 March 2017, Mr and Mrs Hinley were at their home in Lenah Valley. Mrs Hinley went to bed at 8.30pm and observed Mr Hinley sitting up in bed reading. Mr and Mrs Hinley slept in separate bedrooms. Mr Hinley was conscious and talking when Mrs Hinley went to bed.

At 9.30am the following morning, Tuesday 14 March 2017, Mrs Hinley went into Mr Hinley’s room to check on him. When she entered the room she found Mr Hinley lying on the floor on his right side up against the foot of the bed. She found that Mr Hinley was cold to the touch and noted that he had a mark on his forehead and some yellow froth coming from the right side of his mouth. Mrs Hinley checked for signs that Mr Hinley was breathing but could not find any such signs. She then called 000 and was instructed by the operator to commence CPR.

Ambulance Tasmania officers arrived approximately five minutes after Mrs Hinley’s call and continued with CPR. The officers were unable to revive Mr Hinley and he was declared deceased.

Police officers attended the scene to investigate Mr Hinley's death. They found no suspicious circumstances. There was no note or writing by Mr Hinley indicating that he intended to end his life.

On 15 March 2017 an autopsy was performed upon Mr Hinley at the Royal Hobart Hospital by Dr Donald Ritchey. Samples of his blood were also forensically analysed, the results of which showed fatal levels of codeine in addition to toxic levels of paracetamol, mirtazapine and promethazine. In his report, Dr Ritchey stated that the cause of death was mixed prescription drug toxicity with significant heart disease being a contributing cause. I accept the opinion of Dr Ritchey as to the cause of death.

The issue that has occupied the investigation into Mr Hinley's death (and which has been part of the reason for the delay in finalisation) is whether his death from excessive quantities of medication was unintentional or whether he intended to end his life. A further consideration arose regarding whether Mr Hinley was appropriately prescribed medication by Dr Sutherland.

In Mrs Hinley's original affidavit sworn on 14 March 2017, she did not indicate that her husband was prone to excessive use of medication. There was also little evidence in other documents of sustained overuse of prescribed medication.

However, on 4 March 2020 Mrs Hinley swore a further affidavit stating that Mr Hinley was a "self-medicating alcoholic". In addition to consuming excessive quantities of alcohol, she stated that she found quantities of medication after he died that she was not aware he was taking, including pain medication and anti-anxiety medication. She also believed that his prescribed medication was kept in the bathroom and was not aware that it was also located in his bedroom and in the study. She indicated that she believed Mr Hinley would tell his general practitioner that a particular medication was not working so that the general practitioner would give him more medication of a different type.

In her recent affidavit, Mrs Hinley also stated as follows:

*"David talked about suicide with me as we had known people who had done it. David had said we'll know when the time is right and we will go out together. David knew what to take and how much to stock up on. It was generally when he had been drinking. David did not speak about it for the last couple of years and I believe he never intended going through with suicide."*

As a result of the issues arising concerning Mr Hinley's ingestion of medication and the reasons for him doing so, I sought a report from the coronial medical consultant, Dr Anthony Bell. In his report Dr Bell stated as follows:

*“The patient had significant medical issues for many years. Over years there were significant problems with chronic pain, though on the medical records provided where and what the pain was is not described in detail. The treatment according to the prescription records appears appropriate and reviewed on a regular basis. There are records where the patient has called the GP regarding running out of medication before the next prescription, these appear to be handled well, for example buprenorphine patches sweating off in summer. This only appears to have happened on hot days and there was minimal replacement drug prescribed. There appears to have been no escalation of dosage over years. Thus this does not appear to be an addictive behaviour or inappropriate prescribing.*

*The patient had a long history of depression and related anxiety and was treated appropriately. There was review in the last few years by a consultant psychiatrist. The psychiatrist also reviewed the panic attacks and considered the use of long term oxazepam appropriate. On occasions the patient took extra oxazepam and the issue was discussed with the GP. The GP reminded the patient of the addictive nature of the drug and that more drug would not decrease the panic attacks. This appears to be reasonable practice to treat panic attacks.*

*The patient had a probable (insufficient information provided) progressive cerebellar ataxia (inability to coordinate balance, gait, extremity and eye movements). This appears to have been slowly progressive and is the reason for multiple falls described in the patient record. There was no specific treatment, the patient was referred for rehabilitation (Dr D Dunbabin) to improve mobility and education in the use of mobility aids. Improvement was noted.*

*During rehabilitation the patient was found on specific testing to suffer from short term memory loss in particular if interrupted and decreased executive function. This may well have led to poor medication management by the patient. The complexity of managing multiple drugs should not be underestimated. Thus, the use of pre-packaged drug doses with a day and time listed is used to prevent issues. There is no comment in the medical record provided about this method of drug dosing.*

*There is minimal information about the patient’s depressive illness. This suggests that this was a controlled issue and depression was not a major medical issue.”*

It appears that Mr Hinley had current prescriptions for at least 20 medications for his various ailments at the time of his death. These, relevantly, included buprenorphine, codeine / paracetamol-based medications and gabapentin for pain, as well as benzodiazepines and other antidepressants.

At the time of his death, it appears that he had ingested large quantities of the over-the-counter antihistamine sedatives, doxylamine and promethazine. The boxes for these medications were

located in the house. These substances were not prescribed to him by his doctor and I find that he purchased them directly from the pharmacy. It also does not appear that he had a current prescription for the antidepressant, mirtazapine, which was found in his system at toxic levels. It may be that he had stockpiled this medication from a previous prescription or that it had been prescribed to his wife (and he used it without her knowledge). I do not need to determine this issue. Toxicological testing was not available for gabapentin and several other of his prescribed medications which may also have played a part in his death.

Dr Bell commented in his report that there are dangers for persons over 65 years who take promethazine. The forensic scientist who provided a report stated that promethazine enhances the effects of other concurrently administered sedatives such as codeine, mirtazapine, doxylamine, oxazepam and diazepam. This can then result in coma, progressing to respiratory depression or cardiovascular collapse.

I am unable to determine the exact quantity of medication taken by Mr Hinley before his death. However, I am satisfied that he did not intend to end his life at that time by taking excessive medication. Nothing in his behaviour or the appearance of the scene indicates that this was the case.

I accept the opinion of Dr Bell that the prescribing regime was appropriate and I make no criticism of Dr Sutherland's prescribing or treatment of Mr Hinley. Further, Dr Sutherland referred Mr Hinley appropriately to specialists for review, including review of his medication, when necessary.

I find that Mr Hinley was in the habit of buying and ingesting quantities of over-the-counter sedative medication, likely for the purpose of relieving his psychological symptoms. Before his death, he took prescription and non-prescription medication which combined to cause central nervous system depression, unconsciousness and death by respiratory depression.

### **Comments and Recommendations**

The circumstances of Mr Hinley's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I convey my sincere condolences to the family and loved ones of Mr Hinley.

**Dated:** 30 June 2020 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**