MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner)

I, Olivia McTaggart, Coroner, having investigated the death of GW

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

a) The identity of the deceased is GW;
b) GW died in the circumstances described below;
c) The cause of GW's death was acute alcohol (ethanol) toxicity; and
d) GW died in June 2016 in southern Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into GW's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; relevant police and witness affidavits; medical records and reports; and forensic evidence.

GW was born in Tasmania, on 18 July 1985 to parents SF and CW. He was aged 30 years. He has two siblings. At the time of his death GW was single and employed.

GW had a history of alcohol dependence that worsened considerably in the four years prior to his death. For several days at a time he would engage in 'benders' involving consumption of extremely high amounts of spirits and wine. He would attempt to conceal his drinking from family and friends. GW also suffered depression and was prescribed an anti-depressant. On one occasion in 2010 he attempted suicide by cutting his wrists. The evidence reveals little subsequent suicidal ideation.

GW had previously attempted detoxification from alcohol but was unsuccessful in his attempts. Nevertheless, he was under the regular care of his general practitioner and received counselling at Alcohol and Drug Services. He also received a great deal of support from his family members, who also attempted to assist his rehabilitation. The evidence indicates that GW, when not drinking, was an industrious worker.

In February 2016, GW moved into a shared unit with DC. The two did not previously know one another. GW had responded to an advertisement placed on Gumtree by DC, seeking a

housemate. In his affidavit for the investigation, DC states that at the time of moving in GW advised him that he did not drink alcohol but would still be social.

One week after moving in GW confined himself to his bedroom and went on a ‘bender’. He was not seen by DC for several days and did not attend work as required. On the fifth day GW left to go to the bottle shop. DC stated in his affidavit for the investigation that he searched GW’s bedroom and located 10 empty casks of wine, several empty wine bottles and vomit in the ensuite sink.

GW continued to drink alcohol in his room for two more days, during which time his stepmother visited him. During her visit she located 8 empty vodka bottles next to the bed and tipped out open bottles of alcohol in his bedroom. GW apologised to her and admitted he needed help. His employment was subsequently terminated.

GW engaged in further ‘benders’ in the following months, often lasting a week at a time. During such occasions DC would barely see him, but would be assured he was functioning if he saw dishes in the sink. DC stated that during his benders the smell emanating from GW’s bedroom was difficult to tolerate. GW’s father kept in close contact with his son by telephone and delivered groceries to him. He advised DC to tell GW to leave but DC was concerned about breaking the lease and having to cover the rent by himself. Although DC warned GW that he would not continue to tolerate the drinking episodes, the evidence indicates that he was tolerant and supportive of GW.

In April GW attended a counselling session at the Drug and Alcohol Services Community Team. During the session GW told his counsellor that he had had a drinking problem for the past 2-3 years.

GW saw his counsellor again in May and advised her that he had not consumed alcohol for 4 weeks but then had relapsed after securing new employment.

In June GW celebrated his new employment with work friends. He remained in contact with friends over the weekend, however on Monday he did not turn up for work.

On Tuesday GW’s mother, SF, arranged with DC to attend the unit that morning and check in on GW as he had missed work the previous day. When she arrived she located him sleeping in his bed with vomit, urine and faeces in his room. She cleaned up the room whilst he slept. She then arranged for GW to go to Alcohol and Drug Services the next morning with a view to inpatient rehabilitation. Eventually GW awoke and got dressed. SF spoke to him and asked him if he was okay to which he replied that he was. She then left.

GW subsequently left the unit to walk to the bottle-shop. DC left the unit at around midday, and observed that GW had returned from his walk and was sitting against the wall at the front of the unit, next to an empty bottle of vodka. He was frothing at the mouth and dribbling.

DC stated in his affidavit that he had not seen GW in such a state previously due to him only ever drinking in his bedroom. However, he presumed that it was normal for him to appear

this way. He splashed some water on GW and he groaned in response. DC then left the premises.

Later that evening DC returned to the unit and observed that GW was still in the same spot, sitting on a stool and leaning against the wall. DC called out but GW did not respond. DC stated that he believed GW to be sleeping off the alcohol. He wrapped a blanket around him and went inside, leaving the door unlocked.

Early the next morning, DC awoke and checked on GW, who was still sitting on the stool. He sent a text message to SF to let her know that her son had slept outside overnight. He checked GW's bedroom and located 8 empty vodka bottles.

SF arrived at the unit to take GW to his appointment with Alcohol and Drug Services. She observed her son hunched over at the front of the unit, wrapped in a blanket. She tried to rouse GW but was unable to wake him. She observed congealed blood around his nose but stated that this did not concern her as it was not unusual for this to occur when he was on 'benders'. She assumed that he was unconscious.

SF dialled '000' and was advised to commence CPR. DC assisted SF to move GW. In doing so GW fell to the ground. His body was stiff and his arms were held stiffly in the air. DC continued to perform CPR until paramedics arrived. When paramedics arrived they immediately determined that GW was deceased as rigor mortis had set in.

An autopsy was performed upon GW's body by forensic pathologist, Dr Donald Ritchey. He did not observe any marks indicating trauma, and noted the presence of vomitus in his airways. In Dr Ritchey's opinion the cause of GW's death was acute alcohol (ethanol) toxicity, with chronic alcohol abuse, depression and aspiration pneumonia being contributing factors. I accept Dr Ritchey's opinion as to cause of death.

Toxicological testing of blood samples taken at autopsy to which Dr Ritchey had regard returned a vitreous humour reading of 0.524g/100ml, being extremely high. The toxicologist's report received in the investigation states:

> *"Blood alcohol concentrations in excess of 0.4g/mL are potentially fatal and may cause loss of consciousness, respiratory failure and, if there is no supportive care, death. It is reported that alcohol can cause death from a combination of respiratory, cerebral and cardiac depression. Depression of respiration is the most serious toxic effect of alcohol at high concentrations. Deaths have been reported at levels as low as 0.2g/100mL in persons…who have aspirated vomitus, or have obstructed airways (sleeping/unconscious)."*

Police Officers attended the residence and commenced an investigation into the circumstances of death. I am satisfied that this investigation was comprehensive.

I am satisfied that GW died as a result of alcohol toxicity caused by drinking heavily for an extended period prior to his death. I am satisfied that no other person was involved in GW's

death. Based on the evidence it is likely that GW consumed at least 6 bottles of vodka over a period of days and on the day of his death. Sadly, such behaviour was not unusual for GW. All efforts were made to assist and support GW by his family, friends, doctors and counsellors. GW himself expressed a desire to seek help but unfortunately could not overcome his severe addiction.

I note that as part of the investigation affidavits and CCTV footage were obtained from the likely outlets. GW may have obtained the large amount of spirits before his death. However, there is no evidence to enable me to determine where the alcohol was purchased or whether any suppliers did not comply with their duties in accordance with the Responsible Service of Alcohol guidelines.

Comments and Recommendations:

I extend my appreciation to investigating officer Senior Constable Rachael Keygan for her investigation and report.

The circumstances of GW'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 GW.

Dated: 9 April 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner