FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

PAUL WILLIAM LOWE

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Paul William Lowe with an inquest held at Burnie and Hobart in Tasmania, make the following findings.

Hearing Dates

13-15 September 2021 in Burnie, 17 September 2021 in Hobart, with final written submissions received 5 November 2021.

Representation

E Bill – Counsel Assisting the Coroner
G Chen – The Secretary of the Department of Health
D Deayton – Dr Frank Reynolds
M Wilkins (on and from 15 September) – Dr E Okorafo

Introduction

1. Around midnight during the night of 12 and 13 August 2018, Paul William Lowe died at the two bedroom unit he shared with his brother Simon, at Shorewell Park, a suburb of Burnie. Born in Queenstown on Tasmania's West Coast on 11 July 1976, the son of William (Bill) and Sallie-Maree Lowe. He is survived by his parents, brothers Simon and Julian, and daughter Brie.

2. Mr Lowe suffered from a number of significant medical conditions. He was diagnosed with, and treated for, both schizophrenia and epilepsy. His schizophrenia was medicated with a daily dose of the drug risperidone, as well as monthly depot injections.

3. Mr Lowe's epilepsy, which first manifested itself in 2005, was managed by daily doses of zonisamide and levetiracetam. There is ample evidence to support a conclusion that Mr Lowe's compliance with his medication regime was frequently poor, especially in respect of taking his anti-epilepsy prescriptions. Mrs Lowe said that, probably as a consequence of the symptoms of his schizophrenia, her son had times where he thought that the anti-

epilepsy medication was "poisoning him" and refused to take it. Webster packs found in his unit after his death by police showed he was less than diligent in taking his medication. Dr Frank Reynolds, Mr Lowe's General Practitioner (GP) of around 17 years, confirmed in his evidence at the inquest that Mr Lowe was not always compliant with his epilepsy medication, something he said which was not at all uncommon with people suffering from that condition.

4. Dr Frank Reynolds treated Mr Lowe's epilepsy from about 2014. He referred Mr Lowe to a neurologist, who specialises in epilepsy, Associate Professor Wendyl D'Souza, that year. It is clear that Mr Lowe's epilepsy was very serious, and getting worse. It was also, in real terms, almost impossible to treat effectively.

5. At the time of his death, Mr Lowe was the subject of an order under the *Mental Health Act* 2013. He was also participating in the state methadone program at the time of his death, and had been for many years.

6. Mr Lowe's involvement in the methadone program was the result of a long standing issue with the use of illicit drugs. Although a good student and reportedly an excellent Australian Rules Footballer as a teenager, sadly Mr Lowe fell into the use of heroin and other intravenous drugs while living in Melbourne.

7. In 2001 he commenced his participation in the Tasmanian methadone program under Dr Frank Reynolds in Burnie. Dr Reynolds continued to supervise Mr Lowe's involvement in that program for the next 17 years. Upon Dr Reynolds' retirement in April 2018, the last couple of months of Mr Lowe's involvement in the program, and life, were supervised by another doctor at the same practice Dr Emeka Okorafo.

8. At the time he died, Mr Lowe was the subject of an order made under the terms of the *Mental Health Act* 2013. That order, a 'supervision/treatment order' made pursuant to section 39 of the *Mental Health Act* 2013, was first made on 21 April 2017, and renewed shortly before his death. It required Mr Lowe to:

    a) take prescribed anti-psychotic, anti-depressant and hypnotic medication either orally and/or by intra-muscular injection and/or by depot injection;

    b) undergo standard medical and/or blood tests, as well as physical and radiological examinations as directed;

    c) undergo blood and/or urine testing as directed for the purpose of monitoring the use of illicit drugs; and

d) when in the community attend appointments as required with Mental Health Services.

9. Relevantly, the order in force at the time of Mr Lowe's death authorised his admission and detention in an approved facility for the purposes of receiving treatment, if necessary.

10. The *Coroners Act* 1995 provides that where a person was immediately before their death a person 'held in care', an inquest is mandatory. The expression 'held in care' is defined in the Act as meaning: "person detained or liable to be detained in an approved hospital within the meaning of the *Mental Health Act* 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act." Mr Lowe was such a person at the time of his death. Because Mr Lowe was liable to be detained in an approved hospital if he failed to cooperate with treatment, an inquest – a public hearing – had to be held.

The functions of a coroner

11. When a coroner conducts an inquest, they perform a role very different to other judicial officers. The Australian legal system is, in the main, an adversarial process. The coroner's role on the other hand is inquisitorial. This means that the conduct of parties – and their legal representatives – is expected to be different to 'normal' legal proceedings. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner's task is to try to find out what happened, to who and why.

12. A coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[1] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[2]

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[1] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

[2] This function is important both in Australia and overseas. As to the latter, especially in the English context, see 'Coroners' Courts- A Guide To Law And Practice', Third Edition, Dorries, at paragraph 10.13.

13. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

14. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[3] 'How' has been determined to mean "by what means and in what circumstances,"[4] a phrase which involves the application of the ordinary concepts of legal causation.[5] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

15. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone has been established or proved should be approached with a good deal of caution.[6]

Issues at the inquest

16. In advance of the inquest a number of issues, in addition to those mandated by section 28(1) of the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. A draft of the proposed scope was distributed to all interested parties and submissions made as to the proper extent of inquiry at inquest. In the event, I determined that the scope of the inquest would be:

    a) The sequence of events and circumstances that led to Mr Lowe's death, including:

        i. Whether Mr Lowe injected or consumed methadone in the hours prior to his death;

        ii. If Mr Lowe's epilepsy contributed to his death.

    b) Mr Lowe's participation in the methadone program, in particular:

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[3] Section 28(1)(b).
[4] See *Atkinson v Morrow* [2005] QCA 353.
[5] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[6] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

i. The length of his participation;

ii. His compliance with the conditions of that program, including whether he was taking doses as prescribed;

c) Supervision of Mr Lowe's participation in the methadone program by medical practitioners, pharmacists and the Mental Health Service;

d) Steps taken by the Tasmanian Health Service (including Alcohol and Drug Services and the Pharmaceutical Services Branch) to monitor compliance with any authority issued to prescribe methadone to Mr Lowe.

17. The evidence at the inquest necessarily focused on these issues. At the inquest a number of witnesses were called to give evidence. The witnesses who gave evidence were:

- Constable Daniel Dellar, attending and investigating officer, Tasmania Police;
- Constable Dean Wotherspoon, Forensic Services, Tasmania Police;
- Mr Lowe's brother, Mr Simon Lowe;
- Mr Lowe's mother, Mrs Sallie-Maree Lowe;
- Dr Christopher Lawrence, the Forensic Pathologist who performed the autopsy upon Mr Lowe's body;
- Ms Angela Kaplan, a close friend of Mr Lowe's;
- Ms Heather Wild, pharmacist and owner of Wilkinson's pharmacy from where Mr Lowe received his methadone;
- Dr Emeka Okorafo, Medical Practitioner;
- Dr Frank Reynolds, retired Medical Practitioner;
- Dr Adrian Reynolds, former Director of Alcohol and Drug Services, Tasmania;
- Dr Wendyl D'Souza, Neurologist;
- Mr Peter Boyles, Chief Pharmacist, Pharmaceutical Services Branch; and
- Dr Ben Elijah, Director of Statewide Mental Health Services.

18. In addition to the evidence from the witnesses outlined above, a considerable amount of documentary evidence was tendered at the inquest. That evidence included the affidavits of a number of witnesses who were not called to answer questions and Mr Lowe's extensive medical records. The material is set out in the list attached to this finding.

Circumstances of death

19. It is appropriate to deal now with the particular circumstances of Mr Lowe's death. Nothing that follows was in any way in dispute. I find that at the time of his death Mr Lowe was living in a unit in the Burnie suburb of Shorewell. He lived there with his younger brother, Simon. The evidence was that the brothers had lived together for about 12 months – since Simon's release from gaol. Although the unit had two bedrooms, Simon's evidence at the inquest was that he slept on a mattress on the floor of Mr Lowe's room, as until a week before his death Mr Lowe's adult daughter, Brie, lived there. He said that sleeping on the floor next to his brother enabled him to monitor and assist with his seizures.

20. The unit had common areas including a lounge, kitchen and bathroom.

21. Mr Lowe's mental illness and epilepsy made full-time employment challenging, although he did work in a variety of casual roles over the years.

22. In reality his life appears to have been dominated by his mental illness, his epilepsy and his participation in the methadone program. His methadone was dispensed at a pharmacy in the CBD of Burnie, roughly 4 kilometres away. Dr Frank Reynolds said, and I accept, that the distance from the pharmacy was a problem given poor public transport and the fact that, because of his epilepsy, Mr Lowe did not hold a driver's licence.

23. I note that at one stage Mr Lowe's methadone was dispensed at the nearby Shorewell Pharmacy, which was closer to his residence. Dr Frank Reynolds said in his evidence that Mr Lowe changed from the Shorewell Pharmacy in 2015 when the pharmacist was, apparently, 'uncomfortable' with some aspect or aspects of Mr Lowe's behaviour. Apart from observing this report seems to be inconsistent with all other descriptions of Mr Lowe's general behaviour, I think little turns on it. I note that Ms Angela Kaplan, close friend to Mr Lowe, continued to have methadone dispensed to her at the Shorewell Pharmacy.[7]

24. Returning to his daily life Mr Lowe, apart from visits to the pharmacy, seems to have spent most of his time at home with his brother. Simon said in his evidence at the inquest that the pair spent "*98% of their time together*" and this statement, although perhaps hyperbole, gives a clear indication of the amount of time the pair spent in each

[7] See Exhibit 17A, photograph 28.

other's company. The other people Mr Lowe spent time with were his family and friend; Ms Kaplan, his daughter Brie and his parents. Like Mr Lowe, Ms Kaplan was also a participant in the methadone program. She also was a patient of Dr Frank Reynolds, until his retirement.

25. Sunday 12 August 2018 seems to have been unremarkable. There is no evidence of anything unusual happening to Mr Lowe. He and Simon had dinner – a lamb roast cooked by their father – with their parents, at Mr and Mrs Lowe's nearby home. Simon described his brother as being in a "*good place*" on the day of his death.[8] After dinner, Mrs Lowe took her sons to the nearby Shorewell Supermarket (one or other wanted to buy a packet of cigarettes). Mr Lowe kissed his mother on the head and said that he would see her tomorrow. The brothers then returned home.

26. Shortly after arriving home, Simon said Mr Lowe suffered an epileptic seizure at about 6.45pm, in his bedroom. Simon monitored his brother for 2-3 minutes and the seizure ended. Simon said that after the seizure ended his brother "*came good and came out to the lounge, sat down and had a coffee and then [a] smoke.*"[9] The brothers watched television together, before Mr Lowe went to his room to bed at about 9.00–9.30pm.

27. Simon said that neither he, nor his brother, smoked any cannabis that night.[10]

28. Simon remained in the lounge area watching TV. His evidence was that he may have had a nap. Just before midnight, Simon saw his brother lying awkwardly partially on and partially off his bed. Realising something was wrong, Simon checked on Mr Lowe. He was unresponsive and so Simon called 000. While waiting for the paramedics to arrive, Simon carried out cardiopulmonary resuscitation (CPR) on his brother, under the direction of the Ambulance Radio Dispatch Operator. Ambulance Tasmania personnel arrived a short time later, but, despite their best efforts, Mr Lowe was unable to be revived. Resuscitation efforts continued until 12.26am on 13 August 2018, at which time it was apparent Mr Lowe was dead, and he was formally declared deceased. I am satisfied that the response of Ambulance Tasmania was appropriate and timely. The evidence satisfies me that nothing more could have been done to save Mr Lowe.

29. Police arrived at the scene and commenced an investigation. Uniform, Detectives and Forensic officers all combined to carry out that investigation. Mr Lowe's body and the

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[8] Exhibit C12, Affidavit of Simon Allan Lowe, sworn 13 August 2018, page 2 of 2.
[9] *Supra*, page 1 of 2.
[10] *Supra*, page 2 of 2.

scene were carefully examined and photographed. His body was formally identified by his father, and then taken by mortuary ambulance to the Royal Hobart Hospital where it was admitted to the mortuary.[11]

30. A significant amount of what might be described as drug paraphernalia was found at the scene, photographed and seized. Those photographs were tendered at the inquest.[12] They show syringes, a 'bong', used large and small snap lock bags, metal tea spoons, empty bottles of methadone prescribed to Ms Kaplan and Mr Lowe and intravenous lines. Simon Lowe claimed that all the material located by police – apart from the methadone bottles and the Webster packs – belonged to him. Unfortunately, I am not convinced that this was true. The objective evidence found by Dr Lawrence satisfies me that Mr Lowe was injecting something, almost certainly takeaway doses of methadone.

31. Mr Lowe's mother, Sallie-Marie, said in her evidence that she had seen needles and syringes in his wardrobe in his bedroom in a unit in Crowe Street. This must have been sometime between November 2016 and July 2017. Mrs Lowe also said she thought that Mr Lowe was injecting his Sunday takeaway dose, and had been for some time.[13]

32. Simon Lowe's evidence that all the drug related paraphernalia found in Mr Lowe's bedroom belonged to him simply does not stand scrutiny. If it is true then Mr Lowe was injecting methadone, but without using any of the syringes or IV lines (used by IV drug users as tourniquets) found in his bedroom. The proposition is to my mind nonsensical and casts real doubt on this aspect of Simon Lowe's evidence.

33. In reaching this conclusion, I do not overlook the evidence of Ms Kaplan to the effect that she never saw Mr Lowe inject methadone at any time when she knew him, although she did see him orally consume his takeaway dose occasionally on the same day he had already consumed a dose of methadone.[14]

34. I now turn to Dr Lawrence's evidence and the forensic pathology evidence in general.

Forensic Pathology evidence

35. At the Royal Hobart Hospital mortuary, Dr Christopher Lawrence MB BS FRCPA performed an autopsy. Dr Lawrence was at the time the State Forensic Pathologist. He is

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[11] Exhibit C3A, Affidavit of Sergeant Alexander Bonde, sworn 13 August 2018.
[12] Exhibit C17A.
[13] Exhibit C13, Affidavit of Sallie-Marie Lowe, sworn 27 September 2018.
[14] Exhibit C21, Affidavit Angela Kaplan, sworn 23 March 2021, page 2 of 4.

a highly experienced and suitably qualified forensic pathologist who has practiced in the field for over 30 years. Dr Lawrence provided a report that was tendered at the inquest.[15] He also gave evidence as a witness at the inquest. His evidence was clear, precise and very helpful.

36. Dr Lawrence said at autopsy that he found recent and older track marks on the inside of Mr Lowe's right elbow, but no other signs of injury. He photographed those track marks, and the photographs were tendered at the inquest.[16] I note that the same track marks were found and photographed by Constable Wotherspoon, although Dr Lawrence's photographs were clearer. I am quite satisfied that the track or needle marks on Mr Lowe's right arm were not the result of any intervention by Ambulance Tasmania paramedics (who inserted a cannula in Mr Lowe's other arm).[17] Rather, they were, I am satisfied, obvious signs, as Dr Lawrence said of recent and past IV drug use.

37. Dr Lawrence did not find an anatomical cause for Mr Lowe's death such as a stroke or heart attack. He did not find any signs that Mr Lowe had been the victim of a fatal assault or injury of some type. He arranged for samples taken from Mr Lowe's body to be analysed at the laboratory of Forensic Science Service Tasmania. The result of that analysis, tendered at the inquest, demonstrated the presence of fatal levels of methadone, as well as THC (the active constituent of cannabis), risperidone and zonisamide in Mr Lowe's body at the time of his death.[18]

38. Dr Lawrence said in his evidence that while he could not rule out as causes of death Sudden Unexpected Death in Epilepsy (or as it is often known 'SUDEP') or positional asphyxia, he considered the most likely cause of Mr Lowe's death was acute methadone intoxication. I have already explained that the standard of proof in an inquest is the civil standard. Looking at the evidence as a whole, and applying that standard, I consider it is more probable than not that acute methadone intoxication was the cause of Mr Lowe's death. In fact, I think I can be more certain than that. There is clear evidence that Mr Lowe likely injected his Sunday takeaway doses. His death was on a Sunday night. The things found in his bedroom by Constable Dellar, and which Constable Wotherspoon photographed, support the suggestion he was injecting.[19] So do the track marks Dr Lawrence found at autopsy, and photographed, on Mr Lowe's right arm, including a

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[15] Exhibit C4, Post-Mortem Affidavit, Dr Christopher Hamilton Lawrence, sworn 14 November 2018.
[16] Exhibit C30.
[17] See Exhibit C17A, photographs 58 – 60.
[18] Exhibit C5, Affidavit Ms Miriam Grist, Forensic Scientist, sworn 26 September 2018, page 1 of 6.
[19] See in particular photograph 46, part of Exhibit C17A.

recent needle mark.[20] The injection of methadone is something Tasmanian Opioid Pharmacotherapy Program (TOPP) deals expressly with – because it is so very dangerous. The danger of injection is, as Dr Frank Reynolds said in his evidence, that the methadone is delivered to the body in a much higher concentrated dose than if consumed orally in syrup form.

39. On the other hand, SUDEP or positional asphyxia are, to my mind, both much less likely causes of death. SUDEP is really nothing more than an explanation for a death in a person with epilepsy when there is no cause actually able to be identified. It is ordinarily characterised by a deceased person suffering a seizure and then being found face down on a bed. Simon Lowe said he found his brother with his legs on his bed but with his face and torso on the floor – perhaps consistent with a death by SUDEP, perhaps not. But the point in this case is that there is a clear, pathological explanation for Mr Lowe's death. If there had not been, then SUDEP may well be a conclusion open. But in all the circumstances and having regard to the evidence as a whole, I do not think it is.

40. In reaching the view that I have, I had specific regard to Dr D'Souza's evidence. I accept that Mr Lowe had treatment resistant epilepsy, with a degree of worsening seizure control. But there is, to my mind, a clear pathological explanation for Mr Lowe's death – the ingestion by him of a fatal amount of methadone. This objective fact also militates against Mr Lowe's death being due to positional asphyxia.

41. In summary, the evidence of Dr Lawrence, together with the results of the toxicological analysis of samples taken at autopsy and Mr Lowe's history of abusing takeaway doses of methadone, all lead me to conclude he died because of the ingestion by him of a fatal dose of methadone.

42. I am quite satisfied that Mr Lowe's death was not the result of SUDEP. Viewing the evidence as a whole, I am quite satisfied he was using IV drugs, that use included injecting methadone, that he injected methadone in the lead up to his death and the methadone he injected was most likely to have been his Sunday takeaway dose. It was that act which caused his death. To conclude that there is another cause of death is at least inherently unlikely and really nothing more than mere guess work.

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[20] Exhibit C30.

The methadone program

43. Opioid dependence, whether developed as a consequence of prescription medication or illicit drug use, has significant health and social risks. The risks include, amongst other things, premature death, transmission of blood-borne viruses, septicaemia, and psychosocial disadvantage. The use of methadone has been common in this country since at least the early 1990s to attempt to deal with opioid dependence. Opioid dependence is a persistent, relapsing condition which requires substantial and costly treatment.[21]

44. The so-called methadone program (and I will refer to it as such), is a treatment program involving the prescription and dispensing of opioid pharmacotherapy to treat opioid dependence. A patient can only participate in the methadone program following assessment and a determination that they suffer from opioid substance use disorder (or addiction as it is sometimes known).

45. Broadly speaking, the program is designed to facilitate the supply of methadone and buprenorphine to people in the community who have developed an opioid drug dependency to safely address their dependence and potential illicit drug use. The premise underpinning the program is a recognition that the program is no cure for opioid dependence; rather, it is designed to attempt to safely manage what is a chronic condition. To this end methadone and buprenorphine are dispensed in the clinical setting of pharmacies, as a result of a prescription issued by a medical practitioner. The program is subject to a set of guidelines developed in this state by the Alcohol and Drug Service in about 2012. The guidelines – the Tasmanian Opioid Pharmacotherapy Program (TOPP) are just that, guidelines. They have no regulatory force. They are designed as policy and clinical practice standards for medical practitioners and pharmacists involved in the prescription and dispensing of methadone and buprenorphine.

46. Evidence as to the methadone program in Tasmania was given by Dr Adrian Reynolds, the former Clinical Director of the Alcohol and Drug Service (ADS). Dr Adrian Reynolds was responsible for the development of the TOPP Guidelines in 2012. He was, I considered, both well qualified and well placed to give overview evidence in relation to the operation of the methadone program. He said:

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[21] Tasmanian Opioid Pharmacotherapy Program, Exhibit C25, page 12.

> *"The ADS is a Statewide agency that provides treatment to individuals that meet intake criteria, presenting with alcohol, tobacco and other drug related problems. The service is delivered by a multidisciplinary team of medical, nursing and allied health professionals. Clinical services include: inpatient and ambulatory withdrawal management; a range of evidence-based counselling and interventions and services; opioid pharmacotherapy for opioid dependence; smoking cessation clinical support and policy advice to the Department; family support services; youth services; consultation liaison services delivered in the Tasmanian Hospital and primary health care settings; and case management.*
>
> *The ADS sits within the governance structure of Statewide and Mental Health Services, Tasmanian Health Services."*[22]

47. Dr Adrian Reynolds explained that the methadone program relied heavily upon private GPs and pharmacies for its delivery. He outlined the training delivered by ADS to those GPs and pharmacists and detailed the support provided.

48. Mr Peter Boyles, Chief Pharmacist, Pharmaceutical Services Branch (PSB) also gave evidence at the inquest. Like Dr Adrian Reynolds, Mr Boyles is a 'subject matter' expert, whose evidence in relation to the methadone program was considered, precise and helpful. He made the point, a very good one I consider, that it would be preferable for buprenorphine to replace methadone as the drug utilised in the provision of the program. The simple rationale for that suggestion is that buprenorphine is not a drug easily diverted into the community for misuse. The point seems to me beyond argument.

49. In summary, the situation with respect to the methadone program is that PSB grants authority to appropriate medical practitioners to prescribe methadone (or buprenorphine) to drug dependent persons. The authority is subject to the TOPP guidelines, and only those certified by ADS are able to prescribe. PSB has the power to revoke an authority.

50. Data surrounding the prescribing and dispensing activity in this field is reported to PSB through DORA. The information is received primarily to facilitate financial incentives for pharmacists to participate in the program, it being evident that some level of financial incentive was necessary to encourage the participation of pharmacists in the program.

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[22] Exhibit C26, Affidavit of Dr Adrian Reynolds, affirmed 6 September 2021, paragraphs 3 and 4.

51. It is also apparent that the PSB relies on the clinical expertise of ADS, which has no regulatory role but provides formal training, education and administers an 'examination' to be accredited to prescribe. In addition, the ADS provides significant clinical assistance, support and mentoring to doctors and pharmacists involved in the program.

52. It appears to me that the various agencies involved in the regulation administration of the methadone program had good working relationships. As Ms Bill submitted it was clear "*...that the various arms of the agency had good working relationships with each other, and together with practitioners such as Dr [Frank] Reynolds, Dr Okorafo and Ms Heather Wild. The evidence also established, however, that while PSB exercised the regulatory powers, they are reliant on ADS for clinical acumen, with ADS unable to exercise any regulatory role. ADS has a much more "hands on" role with practitioners, and PSB are reliant on non-compliance being reported to them by ADS or practitioners.*"

53. Viewing the evidence in relation to the manner in which the methadone program operated as a whole the weakness in relation to the functioning of the program was the reliance upon personal relationships and informal channels of communication and cooperation. Nonetheless, informality aside, I consider the evidence discloses that the program served Mr Lowe well. The medical practitioners and pharmacists involved were committed, trained and appropriately supported to carry out a difficult task.

54. Mr Lowe participated in the program from June 2001 until his death over 17 years later. As I have already mentioned, almost the whole time he was a participant in the program his treating practitioner was Dr Frank Reynolds. When Dr Frank Reynolds retired in mid-2018, Dr Okorafo took over Mr Lowe's care and, in particular, his involvement in the methadone program.

55. The evidence at the inquest satisfies me that both Dr Frank Reynolds and Dr Okorafo were both appropriately qualified and had completed the necessary training to prescribe methadone and buprenorphine as part of the state methadone program. Dr Okorafo completed his training in July 2018 under Dr Adrian Reynolds. Both Dr Frank Reynolds and Dr Okorafo were familiar with the requirements of the TOPP guidelines.

56. At the time Dr Frank Reynolds retired Mr Lowe was prescribed four takeaway doses of methadone per week. The TOPP guidelines are unequivocal – the maximum number of

methadone takeaway doses per week is two.[23] The rationale for capping the number of methadone takeaway doses available to a patient each week was explained in terms of endeavouring to ensure that takeaway doses would not be abused either by double or even triple dosing by a patient or by diversion of the methadone to other users in the community. In prescribing four takeaway doses per week, Dr Frank Reynolds was not complying with the TOPP guidelines.

57. The guidelines also provide for regular, random and unannounced urine screening. A review of Mr Lowe's medical records indicate that there were lengthy periods between urine screenings whilst Mr Lowe was Dr Frank Reynolds' patient. For example, Mr Lowe's medical records indicate he underwent a urine screening test on 15 December 2016, and then the next on 4 December 2017. Dr Frank Reynolds was asked about this at the inquest and could provide no explanation as to why there had been such delays (in the order of 12 months) other than to point to pressure of work. The guidelines are silent as to the suggested frequency of urine screening but some indication as to how many should occur is, I think, to be found in the fact that Medicare Australia apparently "*limits the frequency of urine drug testing to 21 urine drug tests in the first year of treatment, and 15 tests in following years.*"[24] Although obviously not prescriptive, Medicare Australia's funding regime does suggest that more than one test a year is indicated.

58. I observe that almost the first thing that Dr Okorafo did after taking over responsibility for Mr Lowe's care was to reduce his methadone takeaway doses from four to two per week so as to comply with those guidelines. That reduction came about as the result of discussions involving Dr Frank Reynolds and the ADS - the latter being aware that Dr Frank Reynolds had been prescribing takeaway doses at a level higher than the TOPP permitted. Therefore at the time of his death, Mr Lowe was only being prescribed two takeaway doses per week. Thus on no view of the circumstances were the TOPP guidelines being breached and any earlier breach could not have contributed to Mr Lowe's death. Moreover, although I consider Mr Lowe should have received more regular urine screening testing whilst a patient of Dr Frank Reynolds, I do not consider that fact caused or contributed in any way to Mr Lowe's death either.

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[23] Exhibit C25, Tasmanian Opioid Pharmacotherapy Program – Policy and Clinical Practice Standards, page 96.

[24] Exhibit C25 – TOPP Guidelines, page 91, section 8.5.

Formal findings, pursuant to Section 28(1) of the *Coroners Act* 1995

59. On the basis of the evidence received at the inquest I make the following formal findings.

    a) The identity of the deceased is Paul William Lowe;

    b) Mr Lowe died in the circumstances set out in detail in this finding;

    c) Mr Lowe's cause of death was methadone intoxication; and

    d) Mr Lowe died between 12 and 13 August 2018 at Shorewell Park, Tasmania.

Report on the care, supervision or treatment of Mr Lowe

60. The evidence at the inquest satisfies me that the care, treatment and supervision of Mr Lowe whilst he was the subject of an order pursuant to the *Mental Health Act* 2013 was broadly speaking of an acceptable standard.[25] I have reached this conclusion having regard to the evidence generally but in particular; the TOPP guidelines, the duration of Mr Lowe's participation in the methadone program, and the objective evidence with respect to the treatment he received.

61. I am satisfied that his chronic mental illness was managed as appropriately as the circumstances allowed. It is apparent that Mental Health Services had no awareness of any illicit drug use by Mr Lowe (other than cannabis) whilst he was the subject of either an order or a patient without order.

62. The evidence from Dr Elijah,[26] the medical director of Statewide Mental Health Services (which I accept in its entirety), together with an analysis of Mr Lowe's medical records, satisfies me that the treatment he received for his debilitating mental illness was appropriate and that there were appropriate levels of consultation and communication between those involved in Mr Lowe's treatment as and when necessary.

63. I am also satisfied, having regard to the evidence at the inquest as a whole, that the supervision of Mr Lowe's participation in the methadone program by medical practitioners and pharmacists was appropriate. I note that Mental Health Services had no

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[25] See Exhibit C10.
[26] Exhibit C27, Affidavit of Ben Elijah, affirmed 2 September 2021, generally.

role as such in that supervision but had an expectation that Mr Lowe's treating general practitioner would supervise him in the methadone program.[27] This expectation does not appear to me, in the circumstances, to have been unreasonable, but may benefit from being expressly dealt with if and when the TOPP guidelines are revisited.

64. Finally, I am satisfied that there is no evidence that would support a conclusion that Mr Lowe's care, treatment and supervision, whilst the subject of the order, either caused or contributed to his death.

Conclusion

65. It should be clear, I hope, from the findings set out above that the circumstances of Mr Lowe's death have been comprehensively investigated. I am well satisfied that there are no suspicious circumstances associated with his death. There is no evidence to suggest that any other person was involved in Mr Lowe's death. I do not consider that there was any failure want of care for Mr Lowe on the part of any other person. Having reviewed the circumstances of his death in detail, I do not consider that it is appropriate to make any formal comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

66. I express my particular thanks to Ms Emily Bill counsel assisting. I also acknowledge the excellent work of Constable Daniel Dellar in the investigation.

67. In closing, I wish to convey my sincere and respectful condolences to the family and loved ones of Mr Paul Lowe.

Dated: 2 December 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

[27] *Supra*, paragraph 1(e).

MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

LIST OF EXHIBITS

Record of investigation into the death of

PAUL WILLIAM LOWE

No.	TYPE OF EXHIBIT	NAME OF WITNESS	DATE TENDERED
C1	POLICE REPORT OF DEATH FOR THE CORONER	CONSTABLE DANIEL DELLAR	13/09/2021
C2	DECLARATION OF LIFE EXTINCT	DR H S	13/09/2021
C3A	AFFIDAVITS OF IDENTIFICATION	SERGEANT ALEXANDER BONDE	13/09/2021
C3B	AFFIDAVIT OF IDENTIFICATION	COLIN O'CONNOR	13/09/2021
C4	POST-MORTEM REPORT	DR CHRISTOPHER LAWRENCE	13/09/2021
C5	TOXICOLOGY REPORT	MIRIAM GRIST	13/09/2021
C6	PATIENT CARE REPORT	AMBULANCE TASMANIA	13/09/2021
C7	CONSULTATION NOTES (separate. file)	CITY MEDICAL, BURNIE	13/09/2021
C8	PATIENT HEALTH SUMMARY (separate. file)	BURNIE GENERAL PRACTICE	13/09/2021
C9	MEDICAL RECORDS (separate. file)	THS	13/09/2021
C10	TREATMENT ORDER	MHT	13/09/2021
C11	PSB RECORDS	PSB	13/09/2021
C12	AFFIDAVIT	MR SIMON LOWE	13/09/2021
C13	AFFIDAVIT	MRS SALLIE-MAREE LOWE	13/09/2021
C14	AFFIDAVIT	DETECTIVE SNR CONST. TANEKA DUNHAM	13/09/2021
C15	AFFIDAVIT	SERGEANT ALEXANDER BONDE	13/09/2021

C16	AFFIDAVIT	CONSTABLE DANIEL DELLAR	13/09/2021
C17	AFFIDAVIT	I/C CONSTABLE DEAN WOTHERSPOON	13/09/2021
C17A	PHOTOGRAPHS	I/C CONSTABLE DEAN WOTHERSPOON	13/09/2021
C18	AFFIDAVIT	HEATHER WILD – WILKINSON'S PHARMACY	13/09/2021
C19	STATEMENT	DR FRANK REYNOLDS	13/09/2021
C20	PSB REPORT RELATING TO A KAPLAN	PSB	13/09/2021
C20A	ATTACHMENT 1	PSB	13/09/2021
C20B	ATTACHMENT 2	PSB	13/09/2021
C20C	ATTACHMENT 3	PSB	13/09/2021
C21	AFFIDAVIT	ANGELA KAPLAN	13/09/2021
C22	GP RECORDS RELATING TO A KAPLAN	BURNIE GENERAL PRACTICE	13/09/2021
C23	LETTER	DR EMEKA OKORAFO	13/09/2021
C24	SUPPLEMENTAL PROOF OF EVIDENCE	DR CHRISTOPHER LAWRENCE	13/09/2021
C25	POLICY AND CLINICAL PRACTICE STANDARD	TASMANIAN OPIOID PHARMACOTHERAPY PROGRAM (TOPP)	13/09/2021
C26	AFFIDAVIT	DR ADRIAN REYNOLDS	17/09/2021
C27	AFFIDAVIT	DR BEN ELIJAH	17/09/2021
C28	AFFIDAVIT	PETER BOYLES	17/09/2021
C29	REPORT	DR WENDYL D'SOUZA	15/09/2021
C30	POST MORTEM PHOTOGRAPHS (4 IMAGES)	DR CHRISTOPHER LAWRENCE	14/09/2021
C31	SUPPLEMENTAL PROOF OF EVIDENCE	HEATHER WILD	15/09/2021
C32	SUPPLEMENTAL PROOF OF EVIDENCE	DR EMEKA OKORAFO	15/09/2021
C33	CURRICULUM VITAE	DR ADRIAN REYNOLDS	17/09/2021
C34	CURRICULUM VITAE	DR BEN ELIJAH	17/09/2021