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 pursuant to s57(1)(c) of the Coroners Act 1995)

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

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

a) The identity of the deceased is CE, date of birth 22 August 1950;

b) CE died in the circumstances set out below;

c) CE's cause of death was due to amitriptyline and alcohol toxicity and ischaemic heart disease; and

d) CE died on 22 June 2020, at Launceston, Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into CE's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavits confirming life extinct and identification;
- Affidavit of Dr Christopher Lawrence, forensic pathologist, who conducted the autopsy upon CE;
- Toxicology report of Forensic Science Service Tasmania;
- Tasmanian Health Service Records for CE;
- Summerdale Medical Practice general practitioner records for CE;
- Two reports for the coroner provided by Dr Matthew Johnson, general practitioner of CE
- Affidavit of ZM, wife of CE;
- Medical review by Dr Anthony Bell, coronial medical consultant;
- Report from Pharmaceutical Services Branch and records in respect of prescribing to CE;

- Statement of Nicole Francis, pharmacist who dispensed amitriptyline to CE on 16 June 2020;
- Correspondence from Meridian Lawyers containing further instructions from Nicole Francis; and
- Relevant pharmacy records and copies of prescriptions.

Background

CE was 69 years of age at his death and lived in South Launceston. He was married to ZM and they have two children together. CE also has a son from a previous marriage. CE retired from his employment at Centrelink in 2018 due to suffering anxiety and panic attacks. During his working life he had a variety of jobs, including managing a rental truck business, hotel manager and sales representative.

Throughout his life, CE had always been a heavy drinker. He would consume a 4-litre wine cask every two days. He also smoked cigarettes. In the two years before his death, his alcohol consumption increased further and his wife stated in her affidavit that he would have falls as a result of intoxication.

CE was diagnosed with an anxiety disorder in 2017 and was medicated for his conditions. ZM said that she believed that her husband had become particularly depressed after he retired but he did not speak about what caused his depression. She expressed the opinion that he felt that he was not contributing as he was not working. He would not discuss his mental health with her.

CE had experienced some other physical health issues. In 2010 he was diagnosed with bowel cancer, with surgery successfully removing the cancer. In 2015 he was diagnosed with prostate cancer that was treated successfully by radiation. In 2018 CE broke his left ankle after falling over in the kitchen whilst intoxicated.

Between 2018 and his death in 2020 he had multiple presentations to the Launceston General Hospital (LGH). The first presentation in which he actually expressed suicidal thoughts was 13 March 2018. His inpatient admission at that time was for a period of two weeks, with outpatient psychiatry follow-up after discharge. He was also referred to Alcohol and Drug Services, although it appears he did not fully engage with that service.

On both 18 April and 20 April 2019, CE presented to hospital having apparently accidentally overdosed on his antidepressant, amitriptyline, as well as alcohol. CE did not engage with Mental Health Services as recommended following discharge.

On 9 May 2019 he was prescribed amitriptyline by his general practitioner.

On 13 June 2019 he was again hospitalised after a suspected overdose of amitriptyline and the hospital then ceased prescribing that medication.

On 28 June 2019 he attended his regular general practitioner stating that he had experienced an "epiphany" and had stopped drinking alcohol. He continued to visit his general practitioner regularly but all consultations related to leg issues and reduced mobility. It does not appear that he was taking amitriptyline.

On 1 May 2020 CE had a telephone appointment with his general practitioner, who prescribed him amitriptyline upon CE persuading him that his previous unintentional overdose was in the past. The prescription was for 45 days of amitriptyline, with two repeats, each for the same duration. Dr Johnson explained in his reports for the investigation that he assessed amitriptyline as being an appropriate lower risk medication and that it was being prescribed for the first time in some time in a lower dose. He also discussed with CE the risks of overdose.

On 6 May 2020 CE was hospitalised for an intentional overdose of amitriptyline, which resulted in a three night stay in the intensive care unit and a nine night stay the hospital ward, before being discharged from hospital on 18 May 2020. At that time the doctor, upon the advice of the psychiatry team, recorded in the hospital discharge summary dated 18 May 2020 that amitriptyline was to be ceased and not to be further prescribed to CE. I observe that CE still had a current prescription for that medication together with two repeats. This important advice was not immediately conveyed to Dr Johnson, and I assume that hospital procedures do not require such advice to be provided separately from provision of the formal hospital discharge summary.

On 1 June 2020, Dr Johnson received the discharge summary from the hospital indicating that amitriptyline was not to be further prescribed to CE.

On 15 June 2020, CE had contact with Alcohol and Drug Services and advised, falsely, that he was not drinking alcohol or taking medications, and had not done so for 30 days.

On the same date, 15 June 2020, CE collected his first repeat of amitriptyline on Dr Johnson's prescription from the Meadow Mews pharmacy in Kings Meadows. At this time, CE would have been aware of the hospital advice against taking the medication.

The following day, 16 June 2020, CE presented at the Kings Meadows Discount Pharmacy, a pharmacy he did not use regularly for dispensing his prescriptions, and told the pharmacist that he had lost his amitriptyline prescription in a cab and asked for it to be filled. The

pharmacist, Nicole Francis, dispensed the repeat to CE. He had therefore received 100 amitriptyline tablets in a period of 24 hours.

In assessing whether to fill the prescription, Ms Francis stated in her report for the investigation that CE did not appear intoxicated or affected by substances, was not known as being drug dependent, and there was no instructions from the prescriber for a staged supply nor any restriction as to when the repeats may be filled. She accepted as genuine his account that he had lost his medication in a cab on the way home. She assessed that, upon conducting these enquiries and checks, there was nothing to indicate that she needed to communicate with CE's prescribing doctor regarding any risk in fulfilling the prescription.

Circumstances surrounding death

On Sunday 21 June 2020, CE was at home with his wife and he went to bed alone at 9.00pm.

At approximately 10.30pm ZM went to bed with CE, who was next to her. At approximately 11.15pm ZM woke to CE experiencing a shaking episode lasting about seven seconds. She nudged him to wake him but he experienced another two episodes of shaking with two-minute pauses between them. It appears that she then fell asleep. About 20 minutes later, she heard her son in the house and she again awoke. At that time, she noticed that CE was very quiet, which was unusual as he normally snores. ZM checked to see if he was breathing and could not find a pulse. She called for an ambulance and, following the operator's instructions, she dragged her husband from the bed to the floor and commenced CPR. The evidence indicates that paramedics arrived and continued resuscitation attempts, before pronouncing CE deceased at about 12.30am on 22 June 2020.

Police officers attended the scene to commence a coronial investigation regarding the cause and circumstances of CE's death.

Police searched the deceased's bedroom and located two empty packs of amitriptyline 25mg, each pack containing 50 tablets. Police also located a box of wine in the cupboard that was three quarters empty. Forensic Services officers and CIB officers also attended the scene and photographed relevant medication and prescriptions and seized relevant items. They did not consider that there was any suspicious circumstances surrounding CE's death. Further, no suicide note was located within the residence.

The forensic pathologist determined cause of death to be as a result of the combination of combined amitriptyline and alcohol toxicity together with ischaemic heart disease. At autopsy, CE's heart revealed severe disease with the coronary artery showing 80% stenosis of the left anterior descending coronary artery 60% stenosis of the right coronary artery.

However the level of amitriptyline was at a fatal level with pill fragments found in his stomach. Amitriptyline is a central nervous system depressant which, in overdose, has toxic effects on the cardiovascular and respiratory systems. His blood alcohol level was approximately 0.332g/100mL. Alcohol alone at this level may cause death from a combination of respiratory, cerebral and cardiac depression.

Comments and Recommendations

I am satisfied that CE ingested a large and fatal quantity of amitriptyline tablets with the specific intention of ending his life. These tablets were prescribed to him by Dr Johnson on 1 May 2020 and dispensed to him by two different pharmacies in Kings Meadows on 15 and 16 of June 2020 respectively. He should not have been taking amitriptyline due to his intentional overdose and the requirement that he cease that medication. In any event, he would have been fully aware that the second repeat prescription filled on 16 June 2020 should not have been dispensed to him the day after the filling of the first repeat.

I make no criticism of Ms Francis in the circumstances. She was unaware of CE's recent intentional overdose of amitriptyline and the hospital direction for him to cease that medication. She took reasonable precautions prior to dispensing. She did not have any compelling reason to contact Dr Johnson before accepting CE's (untrue) explanation concerning the loss of his prescription. However, if, out of an abundance of caution she had done so, she may have discovered that he should not have had the prescription filled, as Dr Johnson by that time was in possession of the hospital discharge summary.

I also make no criticism of Dr Johnson. All indications were that CE had been stable for many months before he prescribed him amitriptyline. I accept Dr Johnson's explanation that, had CE consulted him *after* his overdose and hospitalisation, he would not have further prescribed him amitriptyline. Conceivably, Dr Johnson might have, in any event, turned his mind to the repeat prescriptions still available to CE and requesting that CE consult him. However, by that time, he believed that CE's care was being transferred to another general practitioner.

I **recommend** that public hospitals in Tasmania consider implementation of immediate notifications to a patient's general practitioner and to relevant dispensing pharmacies in circumstances where the patient's hospital discharge summary records urgent and critical information pertaining to cessation of, or changes to, a patient's prescription medication.

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

Dated: 25 May 2023 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner