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 S.57(1)(c) of the Coroners Act 1995)

I, Stephen Raymond Carey, Coroner, having investigated the death of Mr S

Find That:

(a) The identity of the deceased in this matter is Mr S;

(b) Mr S died in the circumstances described in this finding;

(c) Mr S died as a result of prescription drug (tramadol) toxicity (overdose);

(d) Mr S died at an unknown time between 11 and 13 March 2014 near Queenstown;

(e) Mr S was born in Victoria and was aged 42 years at the time of death;

(f) Mr S was a married man whose occupation at the date of death was as a mining company employee; and

(g) No other person contributed to Mr S's death.

Circumstances Surrounding the Death:

Mr S had moved to Tasmania with his family in 2007 and had gained employment at a mine in Queenstown. The family lived in Queenstown and consisted of Mr S, his wife, and three of his four children. The family's oldest son resided in Queensland.

During his work at the mine Mr S suffered a significant shoulder injury and despite two surgical procedures he was left with ongoing pain and limitation of use of that shoulder. After his injury he was consistently prescribed significant amounts of opiate pain relief. Due to his injury and his ongoing partial incapacity because of the physical restrictions imposed by that injury, he returned to work as part of the occupational health and safety section at the mine.

Approximately 12 months prior to his death Mr S suffered what appeared to be a period of depression due to the chronic pain and other concerns relating to his ongoing shoulder injury and he was prescribed anti-depressant medication. However, he ceased taking this a short time later due to his concern as to how it made him feel.

During December 2013 an incident occurred at the Mt Lyall Mine which resulted in the death of two employees. As a direct result of this; the mine was shut down, however, Mr S continued his employment working at the front gate of the premises. In January 2014 the mine had returned to production when another incident occurred in which another miner was killed underground, which resulted in the mine shutting down once again. However, Mr S continued his employment at the front gate as the Site Entry Officer. Mrs S states that her husband became moody and withdrawn after the first accident and that he did not appear to fully recover. During the Christmas period of 2013, whilst the family were on holiday in Queensland, he took himself off his opiate medication. As part of his duties at the mine site, after the second death in January 2014, Mr S was required to review CCTV footage of the deceased miner and his movements around the site prior to him going underground where the accident occurred. Mr S described to his wife his feelings of helplessness and frustration viewing this footage. Mrs S describes that her husband's mental health deteriorated rapidly in March 2014, and there did not appear to be any obvious reason for this and he became "*snappy and uncommunicative*". It is reported both by Mrs S and one of his sons that Mr S did not appear to cope well with the deaths that occurred at his workplace. He became concerned regarding the future of the mine and how this would impact upon his employment and he also had a personal connection, having known all of the employees who had died in the mine incidents. Work colleagues of Mr S note that there was nothing out of the ordinary that they noticed about Mr S's emotional or mental state in the period leading up to his death. He had commented upon some problems at home but these were described as being nothing out of the ordinary.

Over the period since his own work accident Mr S had been prescribed with numerous types of analgesic medication including Tramadol (tramadol hydrochloride). As stated previously, he had also been prescribed anti-depressant medication but had discontinued the use of those.

On 11 March 2014 at approximately 8:00pm, Mr S and his wife had engaged in a verbal argument regarding the disciplining of one of the children. This resulted in Mrs S asking that Mr S leave the house, which he did. When he failed to return that night Mrs S formed the opinion that he was still angry and had stayed the night at a hotel. As he had not returned by 12:00pm on 12 March 2014 she contacted several friends in an effort to locate him. At approximately 6:00pm a family friend attended Mr S's workplace and spoke to work colleagues who identified that he had not attended work. On the morning of 13 March 2014 Mrs S attended the Commonwealth Bank, Queenstown and noted that there had been no activity on the family joint account and as a result of this she then attended Queenstown Police Station and notified Mr S as a missing person. At approximately 3:30pm on 13 March 2014 Glenda and Harold Ross, visitors touring Tasmania from the mainland, arrived at the Bird River Walking Track car park where they observed the body of a

male person lying under a picnic table. Initially they thought the person was sleeping however, upon making a closer inspection, they realised the person was deceased. They returned to Queenstown and contacted police. Police officers attended and recognised this male person as Mr S. An inspection of the scene identified nothing suspicious and it was noted that Mr S's vehicle contained a large quantity of empty "Tramadol" blister packs. All of the packets located were prescribed to Mr S on various dates. The post-mortem examination of Mr S identified no physical cause of death; however remnants of 154 tablets identified as Tramadol were located in his stomach. The toxicology results of blood from the post-mortem indicated Tramadol present at 35mg/L which is a significantly elevated concentration with the reported fatal range of that medication being 1.3-20mg/L.

Comments and Recommendations:

I have decided not to hold a public inquest hearing into this death because my investigations have sufficiently disclosed the identity of Mr S, the date, place, cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act* 1999. I do not consider that the holding of a public inquest hearing would elicit any significant information further to that disclosed by the investigations conducted by me.

Given the description of Mr S's mood and behaviour immediately prior to his death it is apparent that he was suffering depression or some other form of significant mental illness. He was clearly concerned and had been impacted by the death of work colleagues, and the possible future of the Mt Lyall Mine, which would have negatively impacted upon his future ongoing employment. He also suffered chronic pain which would also have negatively impacted upon his mental health state. It is apparent that after the argument with his wife he has gathered up a stockpile of Tramadol medication that he had, he has driven to a secluded area and, at some time, has made the decision to consume a very large quantity of medication either with the intention of ending his life or recklessly without giving proper thought to the likely consequences of his action. The decision he made at that time was clearly one made when he was suffering significant mental illness which reduced his ability to make rational decisions. The death of Mr S is a tragedy and likely directly linked to his suffering of significant mental health issues, which unfortunately he apparently did not fully disclose nor realise the danger they created so as to seek appropriate professional help. This case highlights once again the hidden danger of mental illness in the community and the need for everyone to be alert to the signs and aware of the risks they create.

Before I conclude this matter I wish to convey my sincere condolences to Mr S's family.

Dated: 27 January 2015 at Hobart in the State of Tasmania.

Stephen Raymond Carey
Coroner