



# 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 Sue Denise Allie

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

- (a) The identity of the deceased is Sue Denise Allie;
- (b) Ms Allie died in the circumstances described further in this finding;
- (c) I am unable to determine the cause of Ms Allie's death; and
- (d) Ms Allie died on 8 July 2015 at her home in Glenorchy in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Ms Allie's death. The evidence comprises the police report of death; an opinion of the forensic pathologist as to cause of death; relevant police and witness affidavits; medical records and reports; an opinion from the coronial medical consultant; and forensic evidence.

Sue Denise Allie was born in St Helens, Tasmania on 7 August 1951 and was aged 63 years at the time of her death. Ms Allie was separated. She has three adult children, two of whom resided with her at the time of her death. She was a disability pensioner.

Ms Allie had a history of mental illness. From 2005 she came under police attention on several occasions with unpredictable outbursts towards police. In 2013 she impulsively overdosed on temazepam, a sleeping tablet. In 2014 police were called to her residence as she threatened suicide. On this occasion entry to her room was forced and she was taken for a mental health assessment. She told police officers that she had contemplated suicide due to her ongoing illnesses.

Ms Allie also had an extensive history of pseudoephedrine abuse. In 2005-2006 she was the subject of a police investigation for trafficking the drug. She was not charged with any offences but was made subject to a prohibition notice for pseudoephedrine.

Ms Allie is recorded by police as making several attempts to purchase the drug after the imposition of the prohibition notice.

Ms Allie was under the care of a general practitioner, who treated her for depression. She had a current prescription for the antidepressant mirtazapine. She last visited her general practitioner the day before her death, with nothing untoward recorded for the visit except the renewal of routine prescriptions, including mirtazapine.

On 12 May 2015 Ms Allie presented to the Royal Hobart Hospital (RHH) with a sore throat and unexplained bruising on her arms. She was admitted and was subsequently diagnosed with superwarfarin poisoning. Tests revealed that she had been exposed to brodifacoum, a warfarin derivative primarily used in rat poisons.

Anticoagulant rodenticides inhibit vitamin K-1, 25 epoxide reductase, which is required for the activation of coagulation factors II, VII, IX, and X. Anticoagulation is not seen for approximately 48 hours after ingestion in humans. This timing coincides with depletion of factor VII after inhibition of the coagulation pathway. Thus treatment is to provide vitamin K (in large amounts).

Large ingestions, often involving consumption of bait pellets, can lead to profound and prolonged anticoagulation with serious or life-threatening haemorrhage, including gastrointestinal, genitourinary, and intracranial bleeding.

The source of Ms Allie's exposure was not able to be determined by those treating her. She denied any deliberate self-ingestion to hospital staff and stated that she had been handling "Ratsack" since an infestation of mice three weeks prior. She was treated with plasma, clotting factors, and oral and intravenous vitamin K.

Ms Allie further attended at the RHH on multiple occasions during May and June 2015 as an outpatient to monitor her condition. As a result of an apparent worsening of symptoms, she was readmitted to hospital between 4 and 10 June 2015. She was again admitted on 30 June 2015 for the same reason. She was discharged on 1 July and arrangements were made for a community nurse to administer the vitamin K to her at her home for the period of one week. This took the form of injections administered through an indwelling catheter in her arm.

On 6 July 2015 Ms Allie attended the RHH for a check-up with the haematology specialist. Her test results showed a worsening of her condition, which indicated that she had been again exposed to the poison or had stopped taking the antidote. She was offered admission but declined.

On 8 July 2015 Ms Allie was accompanied by her daughter, Cherridan Allie, to attend a morning check-up appointment at the RHH. They returned home around

midday. Ms Allie's eldest son, Benjamin, who resided with her, left with Cherridan to walk the family's dogs. Ms Allie went inside the residence alone and remained by herself. Both Benjamin and Cherridan, in their police interviews for the investigation, described their mother as being in a normal frame of mind when they left the house.

Cherridan and Benjamin returned approximately 15 minutes later. Upon entering the house they immediately noticed that their mother was not in her usual spot in the lounge room. They called out to her but there was no response. They located Ms Allie sitting on the toilet, slumped against the wall. She was unresponsive.

Benjamin immediately dialled '000' and was instructed to move Ms Allie to the hallway floor and commence CPR. Ambulance Tasmania personnel and Police arrived at the scene shortly thereafter. Ms Allie's second son, Joseph Allie, arrived home as paramedics were attending to Ms Allie. Paramedics administered adrenaline and continued CPR for 25 minutes. However, Ms Allie was subsequently pronounced deceased.

Police officers performed a search of the residence and subsequently conducted an extensive investigation into Ms Allie's death.

A screw top syringe was located on the toilet floor of the residence. The syringe contained a residue of brown liquid. Traces of this liquid also appeared to be inside the catheter. A specimen jar containing an unknown brown liquid was also located on top of a rubbish bin in the toilet. Benjamin stated in his police interview for the investigation that he remembered the syringe falling as he moved his mother onto the floor. However, he could not be sure from where it fell.

A large number of prescription medications were also seized by police. No warfarin medications or poisons were located within the house. Ms Allie's children each stated in their police interviews that all rat poisons were removed from the house following their mother's initial diagnosis of poisoning.

The brown liquid within the specimen jar, syringe and indwelling catheter were examined by Forensic Science Service Tasmania (FSST). The substance was determined not to contain any warfarin-based poisons and was consistent with being dirty water. Further testing was considered but deemed futile due to the extreme difficulty of testing for unknown substances.

Dr Donald Ritchey, State Forensic Pathologist, conducted an autopsy upon Ms Allie. Autopsy revealed morbid obesity and advanced cardiovascular disease. Dr Ritchey noted that there was no active bleeding which is the usual mechanism of death in brodifacoum exposure. Toxicological testing of blood samples obtained at autopsy

revealed a lower concentration of brodifacoum than those recently documented by the RHH, indicating no recent additional ingestion or exposure had occurred.

A very high concentration of mirtazapine, an antidepressant medication, was identified in Ms Allie's post mortem blood sample. Although elevated, Dr Ritchey was of the view that death would not necessarily be expected based on this in isolation. The high level is consistent with Ms Allie having ingested a much higher amount of mirtazapine medication than prescribed. Missing tablets from her prescription supply located at the scene supports this fact.

In his affidavit, Dr Ritchey concluded:

*“Although the natural disease identified at autopsy (morbid obesity and heart disease) would account for sudden unexpected death in other circumstances; the presence of the central venous catheter as well as an open syringe containing an unknown liquid in the context of a previous recent mysterious exposure to brodifacoum strongly suggests the possibility of a lethal injection.”*

Dr Ritchey ultimately was unable to determine the cause of Ms Allie's death. I accept the conclusions and observations of Dr Ritchey.

A report upon Ms Allie's previous medical history was compiled by Dr A J Bell, medical adviser to the coroner. Dr Bell undertook a detailed consideration of the available medical records. Dr Bell considered that Ms Allie may have suffered from an undiagnosed factitious disorder, commonly known as Munchausen Syndrome. A factitious disorder is characterised by falsified general medical or psychiatric symptoms where patients deceptively misrepresent, stimulate, or cause symptoms of an illness or injury in themselves to gain examination, treatment, attention, sympathy, and/or comfort, primarily from medical personnel.

In his report Dr Bell stated:

*“Considering the case as a whole the underlying diagnosis appears to be factitious disorder imposed on self commonly known as Munchausen Syndrome. Factitious disorder imposed on self is characterized by falsified general medical or psychiatric symptoms. Patients deceptively misrepresent, simulate, or cause symptoms of an illness and/or injury in themselves, even in the absence of obvious external rewards such as financial gain, housing, or medications. Multiple studies and reviews suggest that in clinical settings, the estimated incidence of factitious disorder is 1%. However, the prevalence ranges widely across different studies. As an example, a study of hospital discharge diagnoses found a rate of only 0.007%. By contrast, a prospective study of patients with fever of unknown origin found that factitious disorder was present in 9%, and a study of psychiatric inpatients found that the incidence was 8%.*

*The first presentation of factitious disorder is usually in the third or fourth decade of life. Onset often occurs following a hospitalisation for either a general medical condition or mental disorder, and factitious disorder appears to develop gradually. Females and unmarried individuals are more likely to suffer the disorder.*

*In this case the taking of rat poison to cause a coagulopathy is a common falsified disease. The patient in characteristic fashion was “relatively unconcerned” about the source of the rat poison. Furthermore the patient did not follow treatment prescribed to aggravate the condition, again a characteristic pattern of behaviour in this illness.*

*The police report is also of interest as indicated in the following extracts: “Next to the deceased on the floor of the toilet was a screw top syringe (to fit the catheter in her arm) the syringe had residual thick black liquid in the end, this liquid also appears to be in the catheter in the deceased’s arm. Next to the deceased in the toilet, on top of a rubbish bin, was a specimen jar with a small amount of the unknown black liquid in it.” This is another marker of factitious illness, injecting dirty water to cause fever.*

*Furthermore the police report continues: “Of interest a packet of Mirtazapine 45mg was located; this was purchased on the 4th of July 2015 with instructions to take 1 tablet daily. From the packet of 30 tablets, 20 tablets were missing and one empty blister of 10 tablets was located in the rubbish on top. If the deceased was taking her medication as prescribed she should have only taken 4-5 tablets, therefore leaving 25-26 tablets unaccounted for leading police to suspect that she may have been over medicating herself, or intentionally overdosing.” This is another part of factitious illness. An overdose is a common method of death in such patients. The patient had toxic levels of mirtazapine on toxicology.*

*The prognosis for factitious disorder imposed on self is poor; recovery appears to be infrequent, especially among patients who are identified later in their course. Patients with comorbid anxiety disorder, depressive disorder, or substance use disorder may have a better prognosis, whereas patients with personality disorders are more refractory. The usual cause of death relates to factitious illness induction.”*

Dr Ritchey was also of the view, upon considering Dr Bell’s opinion, that it is very likely that Ms Allie suffered a factitious disorder.

I observe that treating doctors at the time of her various admissions formed the view that Ms Allie’s poisoning may have been the result of deliberate self-ingestion. Levels in her system were very high suggesting ingestion rather than exposure. Further, a public health inspection was conducted upon Ms Allie’s home, but

determined that there was no risk to health. No pets or other occupants of the home were exposed, suggesting it was not an environmental exposure.

The hospital notes indicate that Ms Allie was relatively unconcerned about the origin of the poisoning. They also indicate a reluctance to follow the prescribed treatment and discharging herself against advice of doctors. On 8 June 2015, for example, there is a detailed nursing note concerning the manner in which Ms Allie attempted to deceive the nursing staff into believing she had taken her vitamin K tablets when she had not.

I am satisfied on all of the evidence that Ms Allie did not comply fully with the required treatment to resolve the symptoms of poisoning.

During her hospital admission Ms Allie stated on one occasion that she believed she was being poisoned by her son, Joseph, with whom she had not been on good terms. Treating doctors therefore scheduled Ms Allie with two meetings with mental health professionals. During these meetings she was adamant that Joseph did not poison her and stated that she did not know the origin of the poisoning. Ms Allie was also offered the chance of initiating a police investigation and to speak with the medico-legal team at the RHH in relation to the origin of the poisoning. She declined these opportunities.

I am satisfied on all of the evidence that Ms Allie intentionally ingested rat poison which resulted in superwarfarin (brodifacoum) toxicity and consequent symptoms. Such actions are consistent with an undiagnosed factitious disorder associated with her severe emotional difficulties.

However, I am satisfied that the ingestion of the poison did not play any immediate role in Ms Allie's death.

I am satisfied that no other person was involved in Ms Allie's death. There is no evidence of motive of any person to wish harm upon Ms Allie. I note that she was not wealthy and had no assets. Each of her children was interviewed at length by CIB officers. I am satisfied, having considered those interviews and the views of the investigating officer, that they were not involved in her death. Both of her sons appeared not to be of high intelligence and it was evident that both cared very much for their mother.

It is possible that, on one or more occasions before her death, Ms Allie administered herself with an unknown substance which may have caused or contributed to her death. It is also possible that her death was caused by her serious heart conditions alone or with contribution from mirtazapine toxicity.

I cannot be satisfied to the requisite standard that Ms Allie, in ingesting excess prescription mirtazapine and/or injecting any foreign material into her body, intended to end her life. It is more likely that such actions were as a result of her tendency to substance abuse and her serious psychological difficulties.

**Comments and Recommendations:**

I am most grateful to First Class Constable Rance Swinton for his thorough investigation and helpful report.

The circumstances of Ms Allie'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 Ms Allie.

**Dated:** 12 October 2017 at Hobart in the state of Tasmania.

**Olivia McTaggart**  
**Coroner**