



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Scott Allen Daniels

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

- a) The identity of the deceased is Scott Allen Daniels;
- b) Mr Daniels died in the circumstances set out further in this finding;
- c) The cause of Mr Daniels' death was positional asphyxia; and
- d) Mr Daniels died between 17 and 19 March 2016 at 17/113 Chapel Street, Glenorchy, Tasmania.

Introduction and background

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Daniels' death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; the results of toxicological analysis of samples taken at autopsy; relevant police and witness affidavits; medical records and reports; and forensic and photographic evidence.

Mr Daniels had struggled with mental health throughout his entire adult life. A number of psychiatric admissions to the Royal Hobart Hospital are documented in his medical records. Mr Daniels was diagnosed as suffering from either schizophrenia or a schizoaffective disorder. In addition, Mr Daniels had a long and significant history of drug and alcohol abuse.

At the time of his death he was under the care of a psychiatric registrar and an occupational therapist at the Glenorchy and Northern District Adult Community Mental Health Service. He had been a patient of that service since 31 October 2014.

On 7 March 2016 Mr Daniels made telephone contact with the Tasmanian Alcohol and Drug Service. The records of that service indicate that he called from a "pub", that he was sick of

drinking and wanted help to stop because it was impacting upon his ability to have contact with his young son, Connor. As a consequence, he was offered an appointment with that service for counselling on Wednesday 16 March 2016. Unfortunately, he did not keep the appointment.

At the time of his death Mr Daniels was prescribed the antipsychotic medications Paliperidone and Olanzapine as well as the antidepressant medication Venlafaxine.

Circumstances of death

At around lunchtime on Thursday 17 March 2016 Mr Daniels met a friend, Mr Luke Christopher Elliot, at the Elwick Hotel, Main Road, Glenorchy. After two or so hours the pair were joined by another man, Mr Christopher Robert Lowe. The group stayed drinking at the Elwick Hotel until about 7.00pm when they walked to the nearby RSL Club.

The evidence is that none of the men consumed any more alcohol at the RSL, although they gambled there for approximately an hour. Eventually, they were asked to leave by staff of the Club. Police assistance was required to effect their removal. At about 8.00pm Mr Daniels was given a formal direction by a Police Officer to leave the area for a period of eight hours.

Mr Daniels, Mr Elliot and Mr Lowe walked together to a nearby pizza parlour and there bought a pizza. The group then walked back to the Elwick Hotel bottle shop where Mr Daniels and Mr Elliot bought a 12-pack of beer. Mr Daniels and Mr Lowe then caught a taxi to Mr Daniels' residence at 17/113 Chapel Street Glenorchy. Mr Elliot did not accompany them in the taxi, instead staying for a time in the central Glenorchy area.

At about 9.00pm Mr Elliot arrived at Mr Daniels' home. Thereafter the three men listened to music, smoked cigarettes and drank the beer that had just been purchased from the bottle shop. In interviews with police after Mr Daniels' death, Mr Elliot claimed that as the group were unable to purchase any marijuana they consumed no drugs that evening. However, Mr Lowe said cannabis was smoked by the men. In light of findings of Forensic Science Service Tasmania that cannabis had been present in Mr Daniels' body at the time of his death, I am satisfied that Mr Lowe's version of events is more likely to be true.

Mr Elliot left Mr Daniels' residence just before midnight and Mr Lowe left about 30 minutes later. Mr Lowe told investigating police later that when he left the residence Mr Daniels was sitting on the couch and slurring his words. He said this was not unusual as Mr Daniels

routinely slurred his words after using cannabis. Mr Lowe said he did not lock the door of the residence as he left.

At about 9.00am on Saturday 19 March 2016 Mr Daniels was found by his brother – Steven – lying on the couch in the living room. Steven thought that his brother was asleep. He left him lying there, leaving the residence and locking the door behind him. At about 3.30pm the same day Mr Elliot, concerned for his friend's welfare as a result of not having heard from him for a couple of days, returned to the residence and looked through the front sliding door. He saw Mr Daniels laying curled up on his left side with his head facing the door. As he could not raise Mr Daniels he contacted the Tasmania Ambulance Service.

Ambulance officers arrived shortly afterwards and entered the premises. They immediately saw that Mr Daniels was dead. No efforts were made to resuscitate him.

The investigation

Police were on the scene at essentially the same time as the ambulance officers. Having been advised by ambulance officers that Mr Daniels was dead investigations were immediately commenced. Mr Daniels was observed to be lying curled up on his left side and back with his head on a sharp angle with his chin on his chest. He was in the same position that his brother, Steven, had seen him in earlier the same day. His mouth was noticed to be slightly open and fluid emanating from his mouth and on his left cheek.

In the kitchen area of Mr Daniels' residence a number of empty beer bottles were found. So were a number of medications with Mr Daniels' name on them. Outside the residence police saw a number of empty beer bottles, primarily on the front porch area.

A careful inspection of the residence gave no cause to suspect the involvement of any other person in Mr Daniels' death. Specifically, there were no signs of a struggle or forced entry to the premises (apart from the damage caused when ambulance officers forced entry to the residence). Mr Daniels' body did not appear to have any injuries or signs of violence.

An officer from forensic services also attended the scene and conducted investigations which assisted the Coronial investigation.

After formal identification by Mr Daniels' brother his body was removed and transported by mortuary ambulance to the Royal Hobart Hospital. At the mortuary an autopsy was carried

out upon Mr Daniels' body by experienced forensic pathologist, Dr Donald McGillivray Ritchey. Dr Ritchey found no signs of violence and no injuries to Mr Daniels' body. He took samples from his body which were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Dr Ritchey expressed the opinion, which I accept, that the most likely cause of Mr Daniels' death was positional asphyxia.

I note the evidence was that Mr Daniels' body was found in an awkward position on a couch in his residence. His head was against the end of the armrest and his neck was sharply flexed. It is apparent from the evidence of Mr Lowe and Mr Elliot, and the results of the toxicological analysis carried out at Forensic Science Service Tasmania, that Mr Daniels had consumed a significant amount of alcohol during the afternoon and evening of 17 March 2016. His blood alcohol level was noted to be highly elevated at 0.220 g per 100 mL of blood. In addition, THC, the active constituent of cannabis, was found to have been present in his body.

Clozapine

Significantly, the drug clozapine was also found to have been present in his body. Mr Daniels was not prescribed clozapine. Clozapine is an atypical antipsychotic medication, often described as a drug of last resort. It is prescribed for patients suffering treatment resistant bipolar and schizoaffective type disorders. It is only prescribed subject to the most stringent of controls.

I am satisfied that the source of the clozapine in Mr Daniels' body was Mr Lowe. The evidence is that Mr Lowe suffered schizophrenia for which he was prescribed clozapine. He told investigating police that he went every day to the office of the Richmond Fellowship (where he lived) to get his medication. Mr Lowe said he was provided with so-called "takeaways" if he was intending to stay otherwise than at the Richmond Fellowship for a night. He told investigating police that on 17 March 2016 he had a night's supply of clozapine with him (4 tablets) as he had intended to stay the night at Mr Daniels' home. He changed his mind and caught a cab home. Mr Lowe said that he put his clozapine (which was in an envelope) on Mr Daniels' kitchen bench so he did not forget to take it. Mr Lowe told investigating police that Mr Daniels 'might' have taken that medication and that he 'might' have left clozapine at Mr Daniels' home before that night. He expressly denied giving Mr Daniels his clozapine to take on that night.

Whilst I am quite satisfied that Mr Daniels consumed clozapine on the night of 17 March 2016 and that the source of that clozapine was Mr Lowe, I cannot rule out that Mr Daniels took it without Mr Lowe's knowledge.

Conclusion

The highly elevated level of alcohol in Mr Daniels' body along with clozapine and cannabis all contributed to him becoming extremely sedated, which in turn caused his death by reason of positional asphyxia. There is nothing to suggest that there are any suspicious circumstances surrounding Mr Daniels' death. I am satisfied that his death was misadventure.

Comments and Recommendations

I **comment** that the fact that clozapine was detected as having been present in Mr Daniels' body at the time of his death is a matter of very great concern. I observe that it is incumbent upon all those involved in the prescription, supply and supervision of the administration of clozapine to ensure that it does not fall into the wrong hands.

The circumstances of Mr Daniels' death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated 7 May 2018 at Hobart in Tasmania.

Simon Cooper
Coroner