



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Michael John Taylor

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

- a) The identity of the deceased is Michael John Taylor;
- b) Mr Taylor died as a result of combined drug and intoxication in the circumstances set out below;
- c) The cause of death was methadone and alprazolam intoxication; and
- d) Mr Taylor died on 13 May 2016 at Blackmans Bay, Tasmania;

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Michael John Taylor's death. The evidence comprises an opinion of the State Forensic Pathologist who conducted the autopsy; results of toxicological testing; police and witness affidavits; medical records and reports; and forensic evidence.

I make the following further findings.

Mr Taylor was born in Hobart on 1 October 1965 and was aged 50 years at his death. He lived with his long term defacto partner IC. Their relationship had commenced in 1999 and continued until about 2006, at which time the couple separated but remained close. In 2014 IC moved back into the jointly owned residence. In April 2016, one month before Mr Taylor's death, IC and Mr Taylor rekindled their relationship.

Mr Taylor suffered from longstanding back pain as a result of uncovertebral joint disintegration. He was under the care of his general practitioner, Dr Dimitrios Klonaris. Since 2005 he had been prescribed opioids for his condition, including endone, oxycontin and methadone. At the time of his death he was prescribed methadone tablets and oxazepam.

IC states in her affidavit in the investigation that she was aware that Mr Taylor injected his pain medication. She said that he was also a regular cannabis user. She described finding Mr Taylor lying on the table and heavily intoxicated by injected drugs about six months before his death.

On 12 May 2016, the morning prior his death, Mr Taylor attended an appointment with Dr Klonaris. They discussed the results of an ultrasound to his abdomen in relation to a suspected hernia and he also collected his prescribed methadone and oxazepam medication.

At approximately 9.00pm on 12 May 2016 Mr Taylor and IC were in the kitchen of their residence. At this time, Mr Taylor advised IC that he had been diagnosed with cancer of the liver and lungs. IC stated that at this time he was unsteady on his feet and, whilst sitting on the bed, he spilt his medication and soft drink. IC assisted him in cleaning up and then they both went to bed. At this time Mr Taylor repeatedly told IC that he was sorry and that he loved her.

At about 1.30am on 13 May 2016 IC woke to Mr Taylor making a strange noise similar to snoring. She attempted to roll him over to stop him but she could not get him to move. A short time later, she realised that he was no longer making any noise. After turning on the light she discovered that Mr Taylor was no longer breathing. She immediately called 000 for emergency services to attend.

Ambulance officers attended and initiated intensive resuscitation efforts for 50 minutes before determining that Mr Taylor was deceased. Police officers, including a forensics officer, attended and commenced an investigation. Attending officers did not observe any trauma to Mr Taylor's body or suspicious circumstances surrounding his death. They noted the presence of large quantities of methadone and oxazepam medication (including empty bottles) in the bedroom.

Dr Christopher Lawrence, State Forensic Pathologist, performed an autopsy upon Mr Taylor. Dr Lawrence identified the following:

- Approximately 17 needle marks in the right and left antecubital fossae and right side of neck (appearing excessive);
- The oesophagus contained green pill fragments;
- The stomach contained 2.3 litres of fluid and dark green pill fragments — suggesting prescription drug intoxication;
- The lungs appeared to be consistent with intravenous drug use, with large deposits of birefringent material consistent with intravenous injecting of oral medication.

A sample of Mr Taylor's blood was obtained and analysed at Forensic Science Services Tasmania. Methadone in the fatal range was detected, as well as alprazolam.

On the basis of the autopsy findings and blood analysis, Dr Lawrence concluded that Mr Taylor died as a result of methadone and alprazolam intoxication. I accept his opinion.

On 25 May 2016, while cleaning Mr Taylor's possessions, IC located drug paraphernalia, which included pic lines, sharps container and four plastic white vials. She gave these to police. The vials were submitted for analysis at Forensic Science Services.

The result of this analysis revealed that three of the four bottles returned a positive indication for methadone; the remaining vial contained 66ml of an unidentified liquid. It is not clear whether the vials which tested positive for methadone previously contained syrup or tablets

diluted by Mr Taylor. It is likely however, that he was diluting his prescribed methadone tablets by crushing or grinding them into a powder, adding saline and then injecting. By diluting and then injecting the methadone he would feel the effects of the drug rapidly.

I cannot determine positively whether Mr Taylor injected the fatal dose of methadone with the intention of ending his life. IC stated that, over the last two years, he had expressed a wish “not to be here”. She also observed that he was particularly depressed in the two weeks before his death and was not behaving as his normal self.

Mr Taylor’s apologetic behaviour to IC immediately before his death, together with his false statement that he had been diagnosed with cancer, seem to indicate that he may have intentionally ended his life. However, Mr Taylor was prone to excessive use of medication and I cannot discount that it was an accidental overdose.

Comments and Recommendations:

A particular issue arises for comment in this investigation.

Mr Taylor is recorded on 8 occasions on the police information system between March 2009 and July 2011. These records relate to him distributing prescription medications, having links to a known Tasmanian drug distribution family and cultivating cannabis. I cannot assume that all of the information provided and contained in these reports is accurate. However, the existence of numerous reports at least gives rise to a suspicion that he was selling his medication, as well as using other substances outside his prescription medication.

As part of the investigation, I sought information from Pharmaceutical Services Branch (“PSB”). PSB, part of DHHS, is responsible for administering the *Poisons Act 1971* and the *Poisons Regulations 2008*. The records of the supply to patients of particular substances (primarily being Schedule 8 narcotic substances such as morphine) must be sent to PSB by Tasmanian pharmacies and are kept on the PSB database, being the Drugs and Poisons Information System (DAPIS). The system records who received the substances and who prescribed them, where and when they were dispensed. The records of all authorities for prescribing issued to prescribers under s59E of the *Poisons Act* are also kept on the database.

PSB is also the central body for receiving notifications from doctors or others where a patient may be “doctor shopping” for any drugs of a high misuse potential. In such cases, PSB often issues notifications to medical practitioners and pharmacies alerting them to the drug seeking behaviour of any particular individual and requesting that they cease or limit supply. Such notifications do not have statutory force under the *Poisons Act* but are sent by PSB at the behest of the treating prescriber with the desire of reducing the harm caused by excessive prescribing and consequent misuse of such substances.

In the case of Mr Taylor, the PSB records do not contain any specific notifications that he was misusing his prescription medication in any way and there is no evidence that PSB had any knowledge of the police reports.

In his report for the coronial investigation Dr Klonaris stated that he recalled one occasion in 2007 when Mr Taylor injected himself. Although his notes do not reflect such an incident. There is no other entry in his notes which indicates that he was, or ought to have been, aware of Mr Taylor's likely abuse of methadone by injecting it or selling it.

If PSB had the police information, that may have been passed on to Dr Klonaris who, in turn, may have considered prescribing to Mr Taylor in a different manner.

It is possible that PSB may have prevented the supply of methadone to Mr Taylor if it became aware of the police information. It is possible that it may have altered the prescribing conditions attached to Dr Klonaris' authority. These are not findings that can be made definitively. However, at a minimum, it would have provided enhanced information to PSB in assessing the risk to Mr Taylor (and others) in issuing authorities to his general practitioner to prescribe him methadone.

In this investigation, I have made enquiries of the three Tasmania Police districts regarding the submission of notifications to PSB when police officers receive reports of misuse of prescription medications or illicit drugs. It appears that procedures do vary between the districts in relation to the supply to PSB of such information.

It may be timely for both Tasmania Police and PSB to review their processes for the mutual sharing of information concerning persons who are reported to misuse prescription medication or use illicit drugs. If such information sharing between the two organisations can be maximised, there is a significantly greater chance of each of those organisations being able to more effectively prevent the great harm caused in this community by misuse of drugs.

Finally, it is relevant to repeat the warning made in previous coronial findings that the practice of crushing medication designed to be taken orally, dissolving it in water and injecting it intravenously is inherently dangerous. The injection directly into the veins of any drug intended to be swallowed can be lethal due to lung and vascular damage caused by the binding substances in the pill. Death can occur in this manner as a result of a single injection.¹

Recommendations

I **recommend** that Tasmania Police and the Pharmaceutical Services Branch, together, develop systems, procedures and/or understandings for the effective sharing of information or reports regarding persons misusing prescription medication.

¹ Mr A 2015 TASCDC 173; Luke Rhodes 2014 TASCDC.

Conclusion

I extend my appreciation to investigating officer, Constable Benjamin Fogarty, for his investigation and report.

I express my condolences to the family and loved ones of Mr Taylor.

Dated: November 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner