



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 Brett Matthew Cashion

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

- a) The identity of the deceased is Brett Matthew Cashion;
- b) Mr Cashion died as a result of an accidental overdose of prescription medication;
- c) The cause of Mr Cashion's death was combined drug (morphine and quetiapine) intoxication; and
- d) Mr Cashion died between 19 and 20 September 2016 in Kingston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Cashion's death. The evidence comprises the Police Report of Death; an opinion of the forensic pathologist who conducted the autopsy; toxicological analysis; family, police and witness affidavits; medical records and reports; pharmaceutical records; and forensic evidence.

Mr Brett Matthew Cashion was born in Tasmania on 9 April 1968 and was 48 years of age at the time of his death. Mr Cashion lived alone at his residence in Redwood Road in Kingston. Mr Cashion spent much of his childhood and life as a young adult in Victoria. After finishing his schooling he trained as a stonemason. Upon returning to Tasmania he engaged in various forms of employment including in the stonemason's industry.

Mr Cashion formed a relationship with Melanie Moran in 2008 and, in 2011, they had a son together, Harley Matthew Cashion. Mr Cashion and Ms Moran were married in 2012. Mr Cashion also has an adult daughter, Ebony Hughes, from a previous relationship although he had not been in contact with her for many years. In 2015 Mr Cashion separated from Ms Moran. In her affidavit for the investigation, Ms Moran stated that the separation occurred as she believed that Mr Cashion was abusing prescription medication.

Mr Cashion had a long and involved history of chronic pain said to arise from back injuries sustained many years previously. He had also suffered depression for many years with accompanying suicidal ideation. Although the medical evidence in this investigation is comprehensive, it is difficult to determine an accurate history of Mr Cashion's injuries, treatment and substance addiction. In her affidavit, Ms Moran stated that Mr Cashion started taking morphine in 1992 when he first hurt his

back. She said that in 2006 he hurt his back again lifting a heavy object at work. Presumably he had surgery for his back at some point as Ms Moran said that he had further spinal surgery in 2007 and was prescribed morphine for pain relief. She said that he abused his prescription drugs (particularly morphine) for a long period of time, that he was obese and a very heavy smoker. She said he did not take care of his health despite being offered a great deal of support by herself and his numerous treating doctors.

Ms Moran said that she had known Mr Cashion to manipulate various doctors to obtain more medication than he would otherwise be prescribed. She said that from 2008-2009 Mr Cashion was required to collect his medication on a daily basis. It is unclear when Ms Moran first became aware that Mr Cashion was misusing his medication. However, she said that at the time of Harley needing hand surgery in Melbourne (in 2014) and afterwards, Mr Cashion frequently visited a doctor, Dr Phillip Hegarty, in Melbourne. She said that Dr Hegarty prescribed him morphine and other medication in addition to his controlled medication regime supervised by his doctors in Tasmania. She said that she believed that Mr Cashion was selling the Valium that Dr Hegarty prescribed. This may be the case, however it is not an issue that I am specifically required to resolve in this finding.

A report in evidence written in 1999 and authored by Mr Cashion's then treating psychiatrist, noted that he was depressed, suicidal, had chronic back pain and was becoming increasingly dependent upon his analgesics. Subsequently, the medical reports and notes obtained in the investigation indicate that Mr Cashion remained with chronic pain, mental health issues and dependence upon prescription drugs, mainly opioids such as morphine, until his death.

From 2008 until his death Mr Cashion was a patient of general practitioner, Dr Ian Almond, of John Street Medical Centre in Kingston. Dr Almond provided a detailed report for the investigation which described his consultations with and treatment of Mr Cashion. In his report, Dr Almond listed the multiple physical and psychological conditions for which he had treated Mr Cashion over the years.

Dr Almond said in his report that Mr Cashion had a long and involved history with chronic pain from a back injury sustained on the mainland before coming to Tasmania. He said that management of this pain and attendant psychological issues proved a challenging and complicated clinical problem, even when specialist help was obtained. He said that there was no surgical solution to his issues and Mr Cashion declined to participate in pain management solutions if it meant ceasing his opioids. He described Mr Cashion as a "*high maintenance patient*", intelligent and with a good knowledge of medical issues. He said that as soon as a particular condition had resolved, Mr Cashion would "*move onto the next*". Dr Almond said that Mr Cashion was always polite, consistent and believable. Significantly, Dr Almond said that Mr Cashion's main issue was his persistent overuse of opioids and

seeking excessive drugs by doctor-shopping. He said that Mr Cashion had a repertoire of excuses in attempting to be issued with more prescription opioids than would otherwise be indicated. Dr Almond doubted that he obtained medication illicitly and said that Mr Cashion was well aware of the real-time reporting system in Tasmania which is a deterrent to doctor-shopping. Dr Almond did not ever have reason to believe that Mr Cashion engaged in the dangerous practice of injecting himself with his prescribed drugs that were intended to be taken orally.

In respect of his overuse of opioids, Mr Cashion was continually re-evaluated by Dr Almond, Alcohol and Drugs Service, Pharmaceutical Services Branch and the Peacock Centre. The records indicate that there was good communication between the various treating health professionals. Nevertheless, Mr Cashion persistently tried to obtain excessive MS Contin (morphine) above what he was prescribed and the records indicate instances of dangerous overuse.

In 2015 Mr Cashion was transferred from Oxycontin to Subutex (buprenorphine) to wean him off opioids, and therefore his prescriptions were from specialists at Alcohol and Drug Services. The change to Subutex was due to Ms Moran leaving him and his requirement to be free of morphine to resume contact with Harley. At the time of his death, Mr Cashion was prescribed Subutex 1.2 mg to be collected daily. He was also prescribed other medication for his mental health conditions, such as Valium and Seroquel (quetiapine).

Circumstances of Death

Mr Cashion spoke regularly to his next door neighbour, Ms Cheryle Paech. Ms Paech provided an affidavit for the investigation in which she said that, about a week before Mr Cashion's death, he told her that he was very happy about a proposed trip to see Harley in Newcastle. Ms Moran confirmed that the trip had been arranged. Ms Paech stated that she observed Mr Cashion's inside house and garage lights continuously on from the evening of 19 September and through the day of 20 September, which she thought was unusual. At about 6.00pm on 20 September she went to Mr Cashion's house with another neighbour to investigate as she was concerned for him. Upon entering the garage, Ms Paech saw Mr Cashion hunched over in a chair, obviously deceased.

Ambulance paramedics and police officers (including forensics, drug squad and CIB officers) attended the scene. The paramedics formally pronounced Mr Cashion deceased, noting that rigor mortis had set in. The police officers observed that, next to Mr Cashion, was a table upon which was located drug paraphernalia, including a small bowl containing a waxy solid. There was a used syringe on the floor next to Mr Cashion's left foot and he had a rolled up trouser leg revealing what appeared to be an injection point on the left shin. It was also noted that Mr Cashion had a small cut to his head, likely caused by him collapsing onto a plastic tub beside him. Attending officers also located a large

amount of prescription medication in Mr Cashion's home. This medication included 11 x MS Mono (morphine) 60mg tablets and 10 x MS Mono 120mg tablets, both labelled as being prescribed by Dr Phillip Hegarty. There were no signs of forced entry to the property and no signs of violence or foul play.

Mr Cashion was transported to the mortuary where the State Forensic Pathologist, Dr Christopher Lawrence, performed an autopsy upon his body. Dr Lawrence noted that there was no apparent anatomical cause of death, although he noted that toxicological testing revealed a "toxic/fatal" level of morphine in his blood and that quetiapine was also present. Dr Lawrence formed the opinion that Mr Cashion died as a result of combined drug intoxication. I accept the opinion of Dr Lawrence as to cause of death. I note also that, when analysed by Forensic Science Service Tasmania, the contents of the bowl and syringe found at Mr Cashion's home were determined to be morphine. There is no evidence that Mr Cashion was suicidal at the time of his death, despite his past history of suicidal ideation. He did not leave any note or other indication that he wished to end his life.

I find that Mr Cashion died accidentally from intentionally injecting morphine prescribed by Dr Hegarty. This morphine was intended to be ingested orally. In coming to this finding, there is no evidence that Mr Cashion was sourcing morphine illicitly at the time of his death. The source of his supply was only that prescribed by Dr Hegarty.

Prescribing Issues Associated with Mr Cashion's Death

The investigating officer, Constable Sam Tilley, identified that the ability of Mr Cashion to obtain MS Mono from Dr Hegarty (over and above the Subutex he was appropriately receiving in Tasmania) enabled him to inject the substance, leading to his death. Subsequently, I have further investigated Dr Hegarty's treatment and prescribing to Mr Cashion. This further investigation culminated in a case management conference on 21 November 2019 in which Dr Hegarty participated with his counsel.

The issues identified in relation to Dr Hegarty as an interested party in this investigation were as follows:

1. Whether the morphine prescribed by Dr Hegarty directly contributed to Mr Cashion's death;
2. Whether Dr Hegarty knew, over an extended period of treating Mr Cashion, that Mr Cashion was receiving medical treatment in Tasmania, was prescribed Subutex and was

known by his medical practitioners in Tasmania to overuse and misuse opioids (including having a propensity for doctor-shopping); and

3. Whether Dr Hegarty, in his role as a general practitioner, should have communicated with Mr Cashion's health care providers in Tasmania, in particular Dr Almond, to ensure the safety of Mr Cashion being prescribed morphine.

Before discussing the above issues, I set out in more detail the facts surrounding Mr Cashion's treatment and consultations with Dr Hegarty.

Mr Cashion first consulted Dr Hegarty on 5 May 2014 after being directed to him by a staff member of the Royal Children's Hospital. Dr Hegarty is a general practitioner at the Parkview Medical Centre situated at Melbourne Private Hospital. At this time, Mr Cashion was in Melbourne for Harley's scheduled hand surgery. Mr Cashion was, as described above, being medicated, treated and monitored by Dr Almond and other Tasmanian health professionals. At this time he was being prescribed by Dr Almond daily doses of MS Mono 180 mg until he commenced daily Subutex dosing in July 2015 prescribed by Alcohol and Drug Services. He was also provided with advance or "take-away" doses of his daily medication to cover periods when he was required to go to Melbourne for matters related to Harley's hand condition. Thus, there was no need at all for Mr Cashion to consult with a doctor or to be prescribed morphine (or indeed, any medication) whilst he was in Melbourne.

Mr Cashion continued to see Dr Hegarty on 15 further occasions, the last consultation being on 14 September 2016. On all or almost all occasions, Dr Hegarty prescribed him 14x60 mg MS Mono and 14x120 mg MS Mono.

Dr Hegarty is an experienced general practitioner who had been working at the Parkville Medical Centre for 20 years at the time Mr Cashion consulted him. He was the main medical practitioner at this centre. Most of his patients were staff members of the Royal Melbourne Hospital, Royal Women's Hospital, the Peter MacCallum Cancer Centre, the Royal Children's Hospital and numerous research institutes in the precinct. It was also a common scenario for the practice to see relatives of interstate patients with a long-term medical condition. In his statement for the investigation dated 16 August 2018, Dr Hegarty outlined that his approach to Mr Cashion's was based only upon Mr Cashion's honesty regarding his medical history, current treatment and management plan in Tasmania. In this regard he stated as follows:

"I saw that my role in Mr Cashion's management was to support the management plans as they evolved, to not make major changes (up or down) in doses or medications, and to make sure that he had support systems in place to help him function on a day-to-day basis, with a long term goal of

opioid reduction or cessation, if and when he was able to do that. As I had never received any correspondence from any of his treating practitioners, I had to determine this by questioning Mr Cashion and by deductive reasoning”.

Dr Hegarty stated that, from the first consultation, it was clear that Mr Cashion had complex physical and mental health conditions, and difficult social and financial circumstances. He had not worked for many years, had chronic anxiety, difficult-to-treat depression and difficulty managing stress and chronic pain. He was aware, through discussions with Mr Cashion, that Mr Cashion was seeing doctors in Tasmania, including attending a psychiatric service and attending a pain clinic. He was also aware that Mr Cashion had seen a psychologist and social worker in Tasmania. Nevertheless, he formed the view that Mr Cashion, despite such levels of support, was unable or unwilling to reduce or stop his opioids which were prescribed to manage his pain.

Dr Hegarty described the treatment goal in prescribing as he did, as being to assist Mr Cashion in maintaining activities of daily living and to have positive social and family relationships. He indicated that his role was “peripheral” and limited to supporting the existing management of the patient. He said that Mr Cashion presented as a “*marginalised person, who felt that the Tasmanian doctors were prejudiced against him and were not taking seriously that he was in chronic severe pain*”. He said that, in the whole context of Mr Cashion’s life circumstances, prescribing him a maintenance dose of morphine was the best decision.

Dr Hegarty said that when he first saw Mr Cashion who was seeking a prescription for morphine, he verified the dosage by observing empty boxes of the medication on printed labels specifying the dose and dosage instructions. Dr Hegarty did not indicate that the labels also showed the name of the Tasmanian prescriber. He said that Mr Cashion’s presentation was credible and indicated a “*proper therapeutic need for medication*.” Dr Hegarty detailed the history given to him by Mr Cashion on each occasion and the various reasons he gave for being in Melbourne. The evidence indicates that many of the reasons were untrue. Similarly, Mr Cashion on each occasion provided what Dr Hegarty considered to be credible reasons for requiring morphine over and above his existing treatment regime in Tasmania.

In his statement, Dr Hegarty said that he had no reason to suspect that Mr Cashion was misusing prescription drugs and did not initiate checks with any databases. He accepted Mr Cashion’s statements as being true as they were always consistent and his treatment in Tasmania, as he described it, reflected the complexity of the situation. He said that, in providing Mr Cashion with minimum quantities of morphine when he was out of state, Dr Hegarty was helping him maintain what was for him a “manageable equilibrium”. He said that at no stage was he informed by Mr Cashion or any medical practitioner that Mr Cashion had been commenced upon Subutex in 2015.

If he had been so advised he would not have provided him prescriptions of morphine. As a matter of fact, both buprenorphine and morphine are opioids and, the use of both at the same time risks a high dose of opioids resulting in sedation, respiratory depression and death. This was a fact known to Dr Hegarty and to Dr Almond.

Dr Hegarty stated that he was of the belief that Mr Cashion's treating practitioners in Tasmania knew that Mr Cashion was consulting him in Melbourne. As a matter of fact, no practitioner treating Mr Cashion in Tasmania was aware that he was seeing a doctor in Melbourne, let alone being regularly prescribed morphine.

Significantly, Mr Cashion told Dr Hegarty at the consultation of 13 October 2014 that he might be going into "detox" in Tasmania and then transferring to Suboxone (buprenorphine) or Methadone. Although he was aware that Suboxone and morphine taken together is contraindicated, he did not believe that Mr Cashion was ready for detoxification and Mr Cashion later told him that he had not agreed to the proposal.

Mr Cashion consulted with Dr Hegarty on 13 September 2016. Mr Cashion told Dr Hegarty that he was more depressed than normal and that he was going to see a psychiatrist in Hobart. On that occasion Dr Hegarty prescribed Mr Cashion; morphine, Valium, Xanax, Seroquel (quetiapine) and Lyrica. It appears that Dr Hegarty also saw Mr Cashion the following day. It is unclear from the records whether he prescribed morphine again on that occasion.

Comments Concerning Dr Hegarty's Prescribing to Mr Cashion

At the case management conference on 21 November 2019, Dr Hegarty was present in person. His counsel, Ms Alexandra Darcey, made submissions orally and in writing on his behalf. In respect of the three issues raised, Ms Darcey submitted as follows:

1. That a finding that the MS Mono prescribed by Dr Hegarty several days before Mr Cashion's death directly contributed to his death is a reasonable finding to make. I have already made this finding;
2. That it is not open to find that Dr Hegarty knew that Mr Cashion was being prescribed Subutex, was known to misuse opioids and had a propensity for doctor-shopping; and
3. It was regrettable that Dr Hegarty had not contacted Dr Almond to ensure that the prescription of the MS Mono was safe.

I accept, on the basis of Dr Hegarty's report, his medical notes and the evidence as a whole, that Dr Hegarty believed what Mr Cashion told him and that Mr Cashion's presentation was coherent and

credible. In particular, I accept that Dr Hegarty did not think that Mr Cashion had hidden from his Tasmanian doctors the fact that he was consulting him in Melbourne on a regular basis. I also accept that Dr Hegarty did not think that Mr Cashion was abusing his medications, was a long-term intravenous drug user and engaged in the practices of drug-seeking and doctor-shopping. In his report, Dr Almond corroborated the fact of Mr Cashion's credibility, stating:

"It would also appear that Mr Cashion, cleverly, was able to keep Dr Hegarty and Tasmanian medical attendants ignorant of each other's consultations and prescriptions.

Had Dr Hegarty contacted myself, or colleagues in Tasmania, the disinformation, inaccuracies and inappropriate prescribing should have come to light. Mr Cashion cunningly and wilfully obscured the true situation and Dr Hegarty's considered desire to help a patient in pain, psychologically and psychiatrically distressed, then took priority.

I had no doubt that at some point Mr Cashion would miscalculate his addiction and dying, most likely accidentally rather than deliberately. Sadly this happened."

Additionally, I accept that Dr Hegarty's patient base consists largely of staff and patients of the hospitals referred to above, not being patients who are dependent upon or who abuse Schedule 8 drugs. Therefore Mr Cashion's profile was atypical for that practice. This fact likely contributed to Dr Hegarty not contemplating to seek crucially important information regarding Mr Cashion's complex drug management regime in Tasmania.

Despite these mitigating matters, Dr Hegarty should have taken steps at an early stage to determine who was treating Mr Cashion in Tasmania and sought Mr Cashion's permission to contact at least his general practitioner to ascertain whether it was appropriate to prescribe potent opioids to him. Mr Cashion was clearly a complex patient and Dr Hegarty should have informed himself to the fullest extent possible by making such contact and seeking advice regarding treatment and prescribing. If Mr Cashion did not give permission for such contact then this would have placed Dr Hegarty on alert and he should not have prescribed. If Mr Cashion did give Dr Hegarty such permission, then Dr Almond (who was fully familiar with Mr Cashion's drug abuse and drug-seeking issues) would have provided the information to Dr Hegarty, who in turn would not have continued to treat Mr Cashion or at least not prescribe morphine to him.

I add that Mr Cashion's death was also contributed to by ingestion of quetiapine. Quetiapine tablets prescribed by both Dr Almond and Dr Hegarty were located at Mr Cashion's house. The fact that Dr Hegarty was not aware of the existing quetiapine prescription by Dr Almond meant that Mr Cashion had a surplus supply. This substance, being a central nervous system depressant, is dangerous in overdose particularly when combined with other central nervous system depressants,

such as morphine. The evidence indicates that Mr Cashion was dosed with his Subutex at 11.00am on Monday 19 September 2016, consuming it in the presence of a pharmacist. Although the substance did not appear in his post-mortem blood sample, I cannot rule out that it may have amplified the effects of the morphine in some way.

In conclusion, Mr Cashion had, for many years, taken excessive amounts of his medication, particularly opioids. He also engaged in the dangerous practice of injecting this medication. In the two years before his death, whilst he was subject to a very strict daily dosing regime in Tasmania, he regularly travelled to Victoria for the purpose of obtaining prescription morphine from Dr Hegarty. He did not advise his Tasmanian doctors that he was regularly being prescribed morphine in Victoria and, from July 2015, it became particularly dangerous for him to take morphine whilst also using Subutex. He appeared credible to Dr Hegarty in providing his history in consultations. However, at no stage over the whole treating period did Dr Hegarty take the obvious and important step of contacting Mr Cashion's treaters in Tasmania to ensure safe prescribing.

I am satisfied that Mr Cashion was fully aware that it was not proper or safe to take the morphine prescribed by Dr Hegarty. He was responsible for his own death in this sense. However, he would not have died at that time if he had not had access to the morphine in the days before his death.

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

I extend my appreciation to investigating officer Constable Samuel Tilley for his high quality investigation and report.

I convey my sincere condolences to the family and loved ones of Brett Matthew Cashion.

Dated: 14 May 2020 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner