MAGISTRATES COURT
TASMANIA

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 s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of QD

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

a) The identity of the deceased is QD;

b) QD died as a result of the voluntary ingestion by her of prescription drugs and alcohol against a background of significant ill-health;

c) The cause of QD's death was combined drug (tapentadol, nortriptyline, venlafaxine, codeine, oxycodone, quetiapine, paracetamol) and alcohol intoxication; and

d) QD died between Friday 1 and Sunday 3 October 2021 at 19 Arthur Street, George Town, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into QD's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Records – Department of Health, Pharmaceutical Services Branch;
- Medical Records – Department of Health;
- Medical Records – George Town Medical Centre;
- Affidavit – Ashley Ferguson, sworn 24 March 2022;
- Interview – Paul Anthony Frost, 8 June 2022; and

- Affidavit – Paul Anthony Frost, sworn 8 June 2022.

Background

In summary, QD had a well-documented history of:

- Morbid obesity;
- Depression;
- Obstructive sleep apnoea;
- Chronic Obstructive Pulmonary Disease;
- Alcohol abuse; and
- Illicit substance abuse.

QD's medical records include evidence of chronic suicidal ideation since her 20s, a suicide attempt in Tasmania in May 2019, and between six and seven mental health admissions in Queensland, at least one after an intentional overdose. Her medical records indicate her recounting a history of suicide on nine or ten occasions throughout her life, all involving the consumption of alcohol and a mix of prescription drugs.

Records held by the State Department of Health, Pharmaceutical Services Branch (PSB) indicate QD was regularly prescribed Schedule 8 opioids prior to her death.

Those records show that on several occasions PSB requested the prescribing general practitioner to supply PSB with results of urine drug screens and physical examinations for signs of continued intravenous drug use. The record show that the GP did not always conduct the screening tests in a timely manner.

Circumstances of death

In the lead up to her death QD was house sitting for her close friend Ms Ashley Ferguson who was the last person to verifiably see her alive at about 3.00 pm on Friday 1 October 2021.

Ms Ferguson found QD's body, in bed, when she returned from a weekend away after 6.00 pm on Sunday 3 October. She realised straightaway her friend was dead and called the police.

Investigation

Nothing was identified at the scene of QD's death giving rise to suspicion or suggesting the involvement of any other person.

Her body was formally identified by Ms Ferguson and then taken by mortuary ambulance to the Royal Hobart Hospital for autopsy. The autopsy was carried out by experienced forensic pathologist Dr Christopher Lawrence. Dr Lawrence did not find any evidence of violence or injury. He did find a significantly enlarged heart with haemorrhagic decomposition in the posterior wall. There was evidence to suggest that QD may have aspirated some of the contents of her stomach.

However, the most significant evidence in relation to the cause of QD's death resulted from the toxicological analysis of samples taken by Dr Lawrence at autopsy. A significant amount of drugs were found to have been present in QD's body at the time of her death. Notably the synthetic opioid tapentadol was found to be present within the reported toxic /fatal range. The analysis also detected the presence of a number of other drugs and alcohol.

I am satisfied that the cause of QD's death was mixed drug and alcohol toxicity. She died as a consequence of ingesting a significant amount of medication along with some alcohol. The combination of drugs and alcohol, along with her obstructive sleep apnoea, morbid obesity and cardiomegaly, led to a depression of her central nervous system and subsequent death.

Conclusion

Although I am satisfied that QD voluntarily ingested the drugs and alcohol which caused her death, I cannot be satisfied to the requisite legal standard that she did so with the intention of ending her own life.

Accordingly, I consider her death was more likely due to misadventure than suicide.

Comments and Recommendations

As I noted earlier, the prescribing general practitioner was less than timely in the provision of information to PSB. It is also difficult to determine how regular assessment and monitoring was in QD's case. I do not think that lack of timeliness caused or contributed to QD's death. Neither do I think that a lack of regular assessment or monitoring necessarily caused or contributed to her death. Nonetheless, in my view it is appropriate to **comment** that it is prudent for general practitioners to conduct regular risk-benefit assessments and monitor for the signs of substance use and abuse when prescribing high-risk effect-modulating medicines, including opioids. It is also essential that general practitioners provide requested information to the PSB within a reasonable time.

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

Dated: 24 July 2023 at Hobart in the State of Tasmania.

Simon Cooper

Coroner