



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 Paul Marcus White

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

- a) The identity of the deceased is Paul Marcus White;
- b) Mr White died as a result of ischaemic heart disease and methylamphetamine intoxication;
- c) Mr White died on 21 June 2014 at 21 Native Rock Road, Railton in Tasmania; and
- d) Mr White was born in Rosebery on 31 March 1972 and was aged 42 years; he was single and was employed as a trades assistant at the date of death; he had two daughters and a step daughter.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr White's death. The evidence comprises an opinion of the State Forensic Pathologist who conducted the autopsy, relevant police and witness affidavits, medical records and reports, and forensic evidence.

I make the following further findings, based upon the evidence, as to how Mr White's death occurred.

Mr White attended the Railton Football Club at 19 Native Rock Road on Saturday 21 June 2014. His intention was to watch the match between Railton and Wilmot. However, he ultimately participated as a player for Wilmot. During the second quarter it appears that he may have received a knock while over the ball. Mr White then complained to the trainer of a hamstring strain. He was told to go to the change rooms to rest and take no further part in the game.

About 15-20 minutes elapsed before half-time was called. When the Wilmot team arrived at the change rooms, Mr White was located lying naked on his back in the shower cubicle by a fellow team mate.

The trainer and others performed CPR upon Mr White as they waited for the ambulance to arrive.

Tasmania Ambulance Service personnel attended the scene and provided emergency medical aid to Mr White for about 20 minutes, including administering adrenalin and amiodarone.

Police officers attended the scene, including members of CIB and Forensics. No suspicious circumstances were identified by them. Mr White's property was searched and a used syringe was located in his backpack. This finding of the syringe was consistent with other evidence in the investigation that indicated a history of illicit drug use by Mr White.

An autopsy was performed upon Mr White by State Forensic Pathologist, Dr Chris Lawrence. Dr Lawrence concluded that Mr White died as a result of the combined effect of ischaemic heart disease and methylamphetamine intoxication. Dr Lawrence stated:

“Autopsy reveals 95% stenosis of the left anterior descending coronary artery and evidence of previous intravenous drug use with track marks as well as healing and possibly recent needle marks. Methyl amphetamine use does predispose to the development of premature coronary atherosclerosis. There is evidence of subacute infarction of the heart muscle suggesting earlier ischaemic heart disease. Methyl amphetamine also has a direct toxic effect on the heart.

Toxicology reveals a blood methyl amphetamine level of 2.0mg/L which is in the toxic range, as well as cannabis.”

I accept Dr Lawrence's conclusion as to cause of death. I conclude that Mr White, upon leaving the football field and entering the change room, injected himself with a fatal quantity of methylamphetamine.

The forensic scientist who analysed the sample stated:

“Methyl amphetamine was identified at an elevated concentration that is reported to result in symptoms of toxicity and/or fatality in some individuals, when used alone. Methyl amphetamine stimulates the central nervous system (CNS), producing behavioural and physiological effects. Although methyl amphetamine has been used therapeutically, its high potential for abuse and other side-effects limit its therapeutic usefulness. Methyl amphetamine elevates mood, increases confidence, increases wakefulness and alertness, and can result in hyperactivity, nervousness and disinhibited behaviour. Unpredictable behaviour and paranoid psychoses can also occur, particularly with repeated use. High doses of methyl

amphetamine can induce hallucinations, paranoia, confusion, restlessness, subjective excitability, irritability, hyperactive reflexes and tremor, panicky behaviour, elevated pulse and blood pressure and increased risk taking. When death is directly attributed to methyl amphetamine poisoning, it is generally due to hypertension, tachycardia and a resulting arrhythmia. Smoking or intravenous administration of amphetamines will produce much higher initial blood concentrations than following oral administration.”

There is no evidence that Mr White intended to take his own life. I find that his death was unintentional.

Comments

Dangers of methylamphetamine use

This finding is published together with my finding in respect of the death of another male who also died after consuming methylamphetamine whilst playing football. It is therefore appropriate to make the following comments regarding the dangers of the consumption of methylamphetamine generally and, more particularly, whilst playing sport or after exertion. I hope that publication of these findings will emphasise the tragic consequences and significant harm that results from its use.

Methylamphetamine (also known as methamphetamine) belongs to the stimulant class of drugs, which also includes amphetamine, ecstasy, and cocaine. These drugs stimulate the brain and central nervous system, resulting in increased alertness and physical activity.

There are three main forms of methylamphetamine: powder (speed), base, and crystal. The research shows that of particular concern is the crystalline form of methylamphetamine, known as “ice”. This is the form of the substance likely consumed by one or both of the deceased before their deaths.

In 2013, 7% of Australians reported that they had used methylamphetamine in their lifetime, and 2% reported using in the past 12 months. Whilst the same proportion of Australians use methylamphetamine now as in 2007, the frequency, form and method of administration has changed, resulting in greater harms.¹

The availability of crystal methylamphetamine has increased, with more users reporting using crystal methylamphetamine rather than lower purity powder methylamphetamine and more regular use. Amphetamine-related helpline calls, drug treatment, arrests and hospital admissions per amphetamine disorders and psychosis have all increased steeply since 2010. The increased availability and use

¹ Roche et al; Methamphetamine Use in Australia; National Centre for Education and Training on Addiction, Flinders University.

of crystal methylamphetamine have been associated with increased regular use and harms.²

It is estimated that in 2013-2014 there were 268,000 regular methylamphetamine users aged 15 to 54 years in Australia. This equates to population rates of 2.09% as regular users and 1.24% for dependent use. This study also noted that the rate of dependent use had increased since 2009 –2010, most markedly among young adults aged 15 to 34 years.³

The National Coronial Information System records that from the period 1 January 2011 until 31 December 2015 there were 1193 deaths reported to a coroner in Australia where consumption of methylamphetamine was determined to be the primary cause of death. Males comprised the majority of these deaths. The National Coronial Information System report notes that the actual number of deaths is likely to be greater due to the number of cases still open.

Dr Anthony Bell, coronial medical consultant, has provided me with a summary of the effects of the use of methylamphetamine, derived from the medical literature. I have, below, extracted the main points from his summary.

Methylamphetamine stimulates the central nervous system, producing behavioural and physiological effects. It has a high potential for abuse and addiction. It may result in fatality in some individuals when used alone on a single occasion.

Use is associated with serious cardiovascular events, including sudden death in patients with pre-existing structural cardiac abnormalities or other serious heart problems. At higher doses there may be dramatic increases in heart rate, blood pressure, respiration and temperature. Hypertensive crisis, hyperthermia, and refractory arrhythmias are associated with severe intoxication.

Methylamphetamine use can cause or exacerbate focal neurologic deficits (impairments of brain, spinal cord and nerve functions) such as central nervous system ischemia, infarction, or haemorrhage. Use may lead to new onset or breakthrough seizure activity. Headaches, nausea and insomnia are also commonly associated with use.

Both acute and chronic methylamphetamine use is strongly associated with a variety of psychiatric symptoms, including anxiety, paranoia and psychosis, delusions, homicidal and suicidal ideation, aggressive and hostile behaviour. Choreiform movement disorders (rapid, jerky involuntary movements) are a relatively common finding in acute methylamphetamine intoxication. Hypervigilance and akathisia (a

² Degenhardt et al; Crystalline methamphetamine use and methamphetamine-related harms in Australia; Drug Alcohol Rev 2016 Jun 11;

³ Degenhardt et al; Estimating the number of regular and dependent methamphetamine users in Australia, 2002 – 2014; MJA 204 (4) 7 March 2016

need to move constantly) may be present in mildly intoxicated persons, while severe intoxication may cause abrupt changes in behaviour, becoming extraordinarily violent. Psychiatric symptoms are often the chief complaint of patients presenting to the emergency or acute care setting.

The main psychological effects of methylamphetamine include wakefulness, alertness, a decreased sense of fatigue, mood elevation, increased self-confidence, and a decreased appetite. Ingestion prevents the safe performing of tasks which require mental alertness. Methylamphetamine use does not create extra physical and mental energy but merely affects the perception of fatigue and pain. Therefore, a person engaged in athletic activity may feel as though they are moving faster and getting stronger when this is not the case. Moreover, methylamphetamine is notable for distorting the user's perception of reality and impairing judgment, which may cause an athlete to participate while ill or injured, possibly leading to exacerbation of pre-existing injuries or illness. Methylamphetamine also predisposes the user to excessive exertion which can lead to heatstroke and rhabdomyolysis (muscle breakdown).

The tragic and untimely death of Mr White highlights the chronic effects of methylamphetamine use upon the heart as well as the toxic consequences of a single injected quantity.

I extend my appreciation to investigating officer, Constable Greg Johnston, for his investigation and report.

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

Dated: 12 September 2016 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner