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, Olivia McTaggart, Coroner, having investigated the death of TX

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

a) The identity of the deceased is TX born 26 May 1992;

b) TX was aged 30 years, was single and lived in Beaconsfield with his parents. He was unemployed. In 2016, TX moved to Tasmania with his parents to be closer to his older sister. He did not wish to leave his home and, following the move, he became increasingly depressed. He found it hard to make friends and did not gain employment. After moving to Tasmania, TX sought treatment for opioid dependence, an issue that had arisen whilst he lived in Sydney.

On 2 May 2019 TX commenced attending the Beaconsfield Family Medical Practice ("Beaconsfield practice") seeking treatment for anxiety and specifically requesting prescription of the benzodiazepine, clonazepam. Over the next three years TX attended the Beaconsfield practice regularly for prescriptions of this same medication. He reported to various general practitioners in the practice that clonazepam assisted his condition. The doses prescribed were gradually increased, from an initial dose of 1 mg per day to 8 mg per day at the time of his death.

In the 12 months before his death, TX's family noticed that he had become reclusive with declining mental health. He suffered suicidal ideation, saying twice to his father in the months prior to his death that he would end his life by jumping from the Batman Bridge. He told his mother that it would be better if he was not here, but reassured her that he would not leave her.

On 3 June 2022 TX was diagnosed with basal cell carcinoma, which caused him significant anxiety. Several days before his death, he said to his mother words to the effect *"it's not the same anymore, my head is not the same."*

In the morning of 30 June 2022 TX was at home and observed by his mother and sister to be particularly sad and sombre in his mood. During the morning, his mother and sister went out, with TX remaining at home. At 4.30pm TX's father arrived home and noted that his son was not present but, unusually, his watch and jewellery were left at home. Being very concerned, he called his wife and the police. Enquiries made by police revealed that TX had attended the nearby Sidmouth store in the morning and, at 10.00am, he had spoken to traffic controllers at roadworks near the Batman Bridge. A police search for TX commenced, also involving the Police Search and Rescue Unit.

At 9.40am the following day, being 1 July 2022, a body was sighted and recovered by the rescue helicopter on the west bank of the Tamar River, about 50 metres south of the Batman Bridge. A wallet containing various cards was found on the body and contained identification in the name of TX. He was subsequently formally identified by his father.

I am satisfied, having regard to the opinion of the forensic pathologist who conducted the autopsy, that TX died as a result of drowning after jumping from the Batman Bridge. Samples of his blood identified that morphine, codeine and thebaine were present, indicating that he had used heroin before his death. Used syringes taken by police from his home confirmed this to be the case. Clonazepam and THC (cannabis) were also detected in his blood.

c) TX's cause of death was drowning due to jumping from the Batman Bridge, an action taken by him alone and with the express intention of ending his life.

d) TX died between 30 June and 1 July 2022 at Deviot, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist who conducted the autopsy;

- Toxicology report of Forensic Science Service Tasmania;
- Tasmania Health Service and Beaconsfield Family Medical Practice records for TX;
- Report by the Chief Pharmacist of Pharmaceutical Services Branch;
- Affidavit of AT, mother of TX
- Affidavit of VR, sister of TX;
- Affidavit of KI, father of TX;
- Affidavit of Kylie Barker, co-owner of Sidmouth Store;
- Affidavit of Jamie Davis, traffic controller;
- Affidavits of seven attending and investigating officers, together with photographs and body worn camera footage;
- Forensic evidence including examination of TX's computer and analysis of drug paraphernalia seized;
- Reports by the Coronial Forensic Nurse; and
- Report from Dr Anthony Lyall, general practitioner at Beaconsfield Family Medical Practice.

Comments and Recommendations

In this investigation, TX's family members questioned whether the clonazepam prescribed to TX contributed to his poor mental state and therefore his suicide. I have also investigated the issue of whether there were opportunities for treatment of TX's mental health by his general practitioner other than the ongoing prescription of clonazepam, a benzodiazepine indicated for short term use only.

In considering these issues, I requested a report and review by Pharmaceutical Services Branch (PSB). PSB is responsible for administering the *Poisons Act* 1971 and *Poisons Regulations* 2018. Its functions, among others, are to record and regulate the prescribing and supply of particular narcotic substances. Clonazepam, although categorised as a "declared restricted substance", is not a substance reportable to PSB. Nevertheless, the PSB report was particularly useful in assisting me with some important information concerning TX's

problematic use of opioids as well as general principles of appropriate prescribing and risk management.

In the report, the Chief Pharmacist stated:

> *"….given TXs opioid use disorder history, if he was prescribed ongoing clonazepam, the health practitioners involved in his care had a duty of care to ensure they were undertaking appropriate targeted risk-benefit assessments frequently, had implemented risk mitigation strategies and had developed a documented treatment plan which included confirmation of a favourable benefit assessment in prescribing clonazepam to TX."*

The report further noted that DORA [1], a real-time prescription monitoring system available to general practitioners, in its landing page for TX contained an alert advising that he had been the subject of a previous circular from 2016 in relation to medications of high abuse potential. The circular was intended to ensure that health professionals viewing the record were cognisant of his opioid dependence when considering prescribing or dispensing high risk affect-modulating substances – in this case, clonazepam.

However, general practitioners at the Beaconsfield practice did not access DORA, as would have been prudent in circumstances of the continuous prescription of a benzodiazepine with high abuse potential. There is no evidence that they were told by TX that he was or had a history of misusing opioid substances. There is also very little information in the practice records about any enquiry made to obtain TXs records from his former general practitioner or the Tasmanian Health Service.

I have had regard in this investigation to the report of Dr Anthony Lyall, a senior general practitioner in the Beaconsfield practice. Unfortunately, his report does little more than repeat the brief consultation notes and does not address, as requested, the concern that he and other doctors in the practice prescribed high-risk medications to TX without undertaking risk mitigation strategies.

I have also had regard to the very helpful analysis of TX's medical records and other medical information by the Coronial Nurse, Mr Kevin Egan.

From what I can ascertain, Dr Lyall suggested in his report that TX was reasonably stable on his prescribed doses of clonazepam, and was mostly reporting to the various general practitioners in the practice who saw him that his anxiety was being controlled by the medication. Dr Lyall's report indicated that he and the other doctors monitored his mental

[1] The Drugs and Poisons Information System Online Remote Access system.

health. However, there is no documentation in the medical notes to indicate how any such monitoring or assessment was completed.

I find that the doctors at the Beaconsfield practice prescribed clonazepam to TX within correct dosage guidelines. Further, there is no clear evidence that TX misused his prescriptions. It also does not appear that he told his doctors that he suffered suicidal ideation and, at times, had plans to end his life. Unfortunately, it seems that TX was not as open with his doctors as he was with his family members. It is trite to say that doctors rely significantly upon the information and history provided to them by their patient in order to provide optimal treatment. However, that fact underscores the importance of a doctor obtaining collateral information concerning a patient and planning treatment goals and risk strategies carefully.

In answer to the question raised by his family, there is no evidence that, in itself, the clonazepam prescribed to TX caused or contributed to his suicide. There is also no evidence that before his death, he took a quantity in excess of what was prescribed to him.

In answer to the issue regarding potential opportunities for TX's general practitioners to better assist his mental state, the following important matters should have been undertaken by his doctors;

- Seeking and obtaining information concerning TX's substance use history via DORA;
- Documenting clear goals of treatment with timeframes and expected undertakings, with such documentation available to all clinicians in the practice;
- Implementing risk mitigation strategies such as frequent urine drug screens, comprehensive patient reviews, and frequent full-bodied checks for any signs of injecting (which may have revealed his heroin use); and
- Implementing a plan to prescribe the lowest effective dose of a benzodiazepine for the shortest possible time in line with correct therapeutic guidelines.

Notwithstanding the above, I am not able to make a finding that different or more thorough treatment would have prevented his death. However, more could have been done to identify the extent of TX's mental health and substance issues, and to implement a considered treatment plan that did not simply involve long-term prescription of a benzodiazepine in increasing doses.

I extend my appreciation to investigating officer Constable Andrew Hansen for his investigation and I acknowledge the efforts of Tasmania Police officers in the search and retrieval of TX.

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

Dated: 22 January 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner