



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 Olaf Paul Alsop

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

- a) The identity of the deceased is Olaf Paul Alsop;
- b) Mr Alsop died as a result of hanging, an action taken by himself with the intention of ending his life;
- c) The cause of death was asphyxia due to hanging; and
- d) Mr Alsop died on 16 March 2019 at Acacia Hills, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Alsop's death. That evidence includes the following:

- a) The Police Report of Death;
- b) Life extinct and identification affidavits;
- c) The opinion of the pathologist who conducted the autopsy;
- d) Toxicological analysis of Mr Alsop's blood sample by Forensic Science Services Tasmania;
- e) Affidavit of Irene Alsop, mother of Mr Alsop;
- f) Affidavit of Christopher Aulich, Baptist Church priest and friend of Mr Alsop;
- g) Affidavits from attending and investigating police officers;
- h) Statement from Dr Esther Papas, Mr Alsop's general practitioner;
- i) Medical records; and
- j) Forensic and photographic evidence.

Olaf Paul Alsop was born in The Hague, in the Netherlands, on 5 August 1964 and was aged 54 years at his death. He was single, had never married and had no children. He lived with his mother in Acacia Hills in Latrobe. Mr Alsop had lived in Sydney and then Queensland as a young man and had worked as a juvenile justice worker and then in a gym. However, he suffered serious, long-term mental health, alcohol and substance issues, as well as chronic back

pain from a work injury. These conditions prevented him from working subsequently, and he received a disability pension. In his later life in Tasmania, he attended his local Baptist Church and took great joy in riding his Harley Davidson motorcycle. Mr Alsop enjoyed a very close relationship with his mother.

Mr Alsop and his family immigrated to Australia from the Netherlands when Mr Alsop was 10 years of age. Mr Alsop's father left the marriage in 2012. Mr Alsop consistently reported to his treating professionals that his father had been emotionally and physically abusive to him and his mother. Over the course of his life, Mr Alsop made several serious attempts at suicide. He had also received inpatient treatment at a number of mental health institutions and alcohol rehabilitation centres before moving to Tasmania in 2008.

Upon settling in Tasmania, Mr Alsop was under the regular care of general practitioners at the Latrobe Family Medical Practice. His medical records indicate that he had been treated for a range of medical issues over the course of his life, including back pain, renal stones, hepatitis C, pulmonary embolism, aspiration pneumonia and post-traumatic stress disorder. He had also been treated for drug and alcohol addiction. He was prescribed a large array of medications, including potent analgesics, for his conditions.

In 2013, Mr Alsop's half-brother died by suicide, which caused Mr Alsop great grief. During this year, he developed an addiction to his prescription medication and would travel to multiple pharmacies seeking codeine. His regular general practitioner, Dr Esther Papas, advised him to attend Alcohol and Drug Services to consider a drug withdrawal program. She also commenced to carefully regulate his prescription analgesia, including by implementing a weekly pick-up at one local pharmacy.

In November 2017, Mr Alsop presented to hospital having overdosed on 60 Panadeine Forte tablets.

In August 2018, Mr Alsop was diagnosed with terminal lung cancer. He was a long-term and heavy smoker. Given his prognosis, he was not treated actively after January 2019 and commenced palliative care. From the point of Mr Alsop's diagnosis, his repeated requests to Dr Papas and the hospital for pain medication escalated to a concerning level.

Mr Alsop's visits to Dr Papas increased, consulting with her on 14 occasions in the two months before his death, constantly seeking more medication than Dr Papas considered to be appropriate to manage his pain.

On 12 March 2019, Mr Alsop presented to the Mersey Community Hospital Accident and Emergency Department. He stated that he would commit suicide if his pain was not relieved. During this hospital presentation, his treating health professionals formed the view that his pain was not as severe as he conveyed and became suspicious that he was seeking potent addictive medication to stockpile and sell. This opinion was conveyed to Dr Papas.

On 14 March 2019, Mr Alsop attended Dr Papas who provided him with a letter stating that she would no longer treat him due to concerns over longstanding issues of honesty relating to his medication requirements and use. This letter was provided on the advice of her insurance company. She explained to Mr Alsop that there were other local general practices that would accept him as a patient and she gave him a list of those practice names and telephone numbers.

Circumstances Surrounding Death

On both 14 and 15 March 2019, Mr Christopher Aulich visited the home of Mr Alsop. On those occasions, both Mr Alsop and his mother expressed distress at the decision of Dr Papas to cease treating Mr Alsop. In his affidavit, Mr Aulich said that on 15 March 2019 Mr Alsop appeared to be having a 'heightened response' to the letter from Dr Papas and also that he seemed physically weak.

On 16 March 2019, Mrs Alsop went to have a sleep in the early afternoon and, when she woke, she located Mr Alsop hanging from a rope under the patio of the house. He was deceased. She telephoned Mr Aulich, who in turn telephoned for an ambulance and police.

A full investigation into Mr Alsop's death subsequently took place. The police officers attending the scene of death, including forensics and CIB officers, were of the opinion that there were no suspicious circumstances indicating the involvement of any other person in Mr Alsop's death. I accept that this is the case. The officers located a large number of empty prescription pill packets in the lounge room. They concluded that Mr Alsop had placed the rope noose around his neck and secured it to a beam of the patio roof. He had then stepped off from some stacked milk crates. He did not leave any note or writing regarding his intentions.

Mr Alsop was formally identified by his mother. He also underwent autopsy, conducted by forensic pathologist, Dr Christopher Lawrence, who concluded that the cause of his death was asphyxia by hanging. Dr Lawrence also observed that Mr Alsop had widespread carcinoma of the lung and there were a large number of pill fragments in his stomach. Toxicological analysis of his blood sample identified no alcohol in his system but there was a range of his prescription drugs in his body but not at levels that indicated toxic overdose.

I am satisfied that Mr Alsop took the action of hanging himself with the express intention of ending his own life.

Comments

In this investigation, Mrs Alsop raised concerns over her son's treatment by Dr Papas as well as the other doctors treating his cancer. In particular, she questioned Dr Papas' cessation of treatment and its role in Mr Alsop's death.

In response to the concerns by Mrs Alsop, I sought and received a detailed report from Dr Papas. She first saw Mr Alsop in 2008 and commenced treating him regularly in 2013 until his death. Both the contents of the report and her treating records clearly indicate that she had implemented a careful prescribing regime involving appropriate rules and arrangements with pharmacists, and later, oncologists and palliative care professionals, to ensure that he received sufficient prescribed medication with reduced access so as to prevent misuse.

Dr Papas' medical notes over the years of treating Mr Alsop were clear and detailed. Those notes showed that her treatment and care of him over a period of 10 years was appropriate, thorough and compassionate. There is no evidence that she or any other doctor responsible for treating Mr Alsop fell short of proper standards in his/her treatment. Most importantly, all treating health professionals were mindful of his suicidal risk and his excessive use of substances.

The decision of Dr Papas to cease treating Mr Alsop was carefully considered and no doubt a difficult one for her to make. Nevertheless, her decision was fully justified in light of the trust issues surrounding Mr Alsop's escalating drug-seeking behaviour. Mr Alsop was upset about this decision and his resulting emotional state may have, to a degree, impacted upon his decision to end his life. However, it cannot be said that Dr Papas in any way contributed to his death.

Unfortunately, Mr Alsop had suffered serious suicidal ideation and substance issues for many years and had a range of physical health issues, including widespread lung cancer for which he was receiving palliative care. He had a history of suicide attempts. His death in such circumstances was not surprising but could not have been prevented by any person.

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

I convey my sincere condolences to the family and loved ones of Olaf Paul Alsop.

Dated: 16 July 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner