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)

I, Olivia McTaggart, Coroner, having investigated the death of MB

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

a) The identity of the deceased is MB;
b) MB died in the circumstances set out in this finding;
c) The cause of death was mixed prescription drug toxicity (tramadol and alprazolam); and
d) MB died in December 2015 at Lime Bay, Tasmania;

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

I make the following further findings.

MB was born in Queensland in July 1992 and was aged 23 years.
He lived at home with his parents in southern Tasmania. He was not in employment.

Upon completing his schooling in Launceston, MB moved into accommodation with his girlfriend. During this period MB's weight reached around 240 kilograms and he had become significantly immobile. He had also started to suffer serious mental health issues, manifesting in depression, anxiety and self-harm.

In 2011, MB's parents became so concerned for their son's well-being that they took him back to their home to care for him and, when he was well enough, supported him whilst he

underwent lap band surgery. Whilst living on the east coast MB was treated by his general practitioner at the East Coast Medical Centre.

MB lost about 100 kilograms in weight in the 12 months after his surgery. However, he suffered serious depression and often flew into fits of violent rage combined with attempts at self-harm. MB's fits of rage had become so extreme that his mother was forced to put a lock on her bedroom door in order to protect herself. He expressed suicidal ideation to his general practitioner.

MB's mental health issues were being treated by his general practitioner and psychiatrists with a variety of medications. Eventually, MB was prescribed alprazolam, a medication primarily used to treat anxiety and panic disorders. MB often misused this medication by taking more than that prescribed. Between 2013 and 2015 MB had various admissions and referrals for treatment to the Hobart Clinic at Rokeby and then at the Royal Hobart Hospital.

In early 2015, MB formed another relationship, which ended after a short time. MB was highly distressed at the break-up and, in July 2015, he took an overdose of alprazolam and inflicted a knife wound to his arm. He was taken to the Royal Hobart Hospital for medical treatment and mental health assessment. MB's mother stated that subsequently her son's mental and physical health seemed to improve greatly. She said that he commenced exercising at the gym, was happier and had enrolled in a psychology course to help him become a counsellor for others. He was also planning to build a house and to make a trip to Queensland to visit his grandfather. She stated that he was able to reduce his need for medication.

MB was good friends with RH. RH invited MB to join a small group of people for a camping trip to Lime Bay on the Tasman Peninsula in December 2015. MB was both excited and anxious about the trip.

MB attended his general practitioner before the planned camping trip. Although he had not been taking alprazolam over recent months, he asked for an alprazolam prescription. The general practitioner's notes do not indicate that MB told her that he was anxious about the upcoming camping trip. However, it does appear that his feelings of anxiety and depression prompted his request for the prescription.

The small group and MD travelled from Hobart in various vehicles to the camping grounds, arriving around mid-afternoon. The group set up the various tents and equipment close together, although MB set up his tent a short distance away from the other group members as

he expressed a desire for a different position. Scattered around the campsite were approximately 30 to 40 individual groups comprising at least 100 campers.

The other group members have provided affidavits in the coronial investigation. It appears from their evidence that they enjoyed MB's company. They were also aware of his anxiety and mental health issues and were accepting and tolerant of him. The other group members stated that MB was consistently in good spirits during the camping trip and there was no indication that he was intending to harm himself in any way.

The evidence indicates that the members of the group consumed only moderate quantities of alcohol. In particular, MB consumed two or three alcoholic drinks on one evening but none after that time. The evidence also indicates that the group were happy and civil in their behaviour throughout the trip.

Whilst on the camping trip, MB and RH travelled to Hobart and collected GC and her 18-month-old son. They then all travelled back to the Lime Bay camping grounds. That evening, the group shared an evening meal and stayed up late talking around a campfire. MB retired to his tent at about 2.00am the following morning. RH recalls seeing a light emanating from MB's tent after he retired.

Later that morning, the members of the group awoke at various times although MB did not emerge from his tent. At about 11.00am RH checked on him. Upon hearing a sound, she called out to him with no response. She stated that she opened the tent flap and saw that MB was lying on his side and breathing. She said that she therefore did not bother him further. I accept that RH went to MB's tent at about this time, although the eyewitness evidence of another member of the group, KH, causes me to doubt whether she opened the tent. I am not required to resolve this conflict.

RH stated that she subsequently heard movement in the tent between 12.00pm and 2.00pm, but when MB did not come out she assumed that he had gone back to sleep. Again, this may or may not have occurred. Understandably, RH was a very good friend of MB and, in providing her affidavit in the coronial investigation, she may have wished to portray that she took all possible steps to check his welfare.

At around 4.00pm that afternoon, KH returned from fishing and was advised by RH that MB was not yet awake. In company with RH and another group member, KH went to check upon MB in his tent. When they opened the tent, they saw MB lying there, apparently deceased. His

body was rigid, with white foam and mucus around his nose and mouth. He did not respond to attempts to rouse him. They called 000 and acted upon instructions to perform CPR.

Ambulance Tasmania paramedics arrived at the scene and police arrived shortly afterwards. Paramedics confirmed that MB was deceased. The scene was left undisturbed until forensics officers arrived to photograph and search the scene. Relevantly, a number of prescription medications were located in MB's tent, including Zydol, a brand name for tramadol which is a painkiller belonging to the class of opioids that act upon the central nervous system. Zydol capsules are used for the treatment of moderate to severe pain. There were five capsules missing from the slide.

Other medications, wound creams, dressings and paraphernalia were also located in the tent in an open first aid kit. MB's body was removed from the tent and examined. There were no suspicious marks or anomalies indicating foul play. MB was conveyed to the Royal Hobart Hospital Mortuary for autopsy.

An autopsy was conducted by pathologist, Dr Donald Ritchey. He determined that the principal cause of MB's death was mixed prescription drug (tramadol and alprazolam) toxicity. In coming to this conclusion, Dr Ritchey had regard to the toxicological testing of MB's blood revealing the presence of tramadol in toxic quantities as well as alprazolam. Dr Ritchey stated that significant contributing factors were early aspiration pneumonia, morbid obesity and depression. I accept Dr Ritchey's opinion as to the cause of death.

MB's mother supplied two affidavits in the coronial investigation. In her initial affidavit of 1 July 2016, she stated that in the weeks before the camping trip MB had received an accidental wound to his foot whilst kayaking which had become infected. On that basis, she had prepared a small first-aid kit for MB to take on the camping trip with the only medication in that first-aid kit being Panadol. In that affidavit, she stated that her son may have taken her prescription tramadol on his camping trip without her knowledge.

However, upon further questioning by police, MB's mother made another affidavit on 1 June 2017. In that affidavit she stated that she had packed at least two blister packs of tramadol for MB in the first-aid kit. Both she and her husband were prescribed tramadol. She said that she provided that tramadol for him to use if the pain in his injured foot became too great.

MB's mother stated in her second affidavit, *"I told MB that I had put some tramadol in the kit and if his foot got really sore to take a couple. I know that MB had taken some of our prescription tramadol previously due to pain in his back from being so overweight, though we*

had told him to take one of these tablets at a time only and to take them with food, he knew this". I do not accept that MB suffered a foot injury as described by his mother, or at least one requiring opioid analgesia prescribed for moderate to severe pain. The forensic pathologist did not note any infective injury to MB's foot. The examination of his body by forensics officers did not note any foot injury.

I find that MB's mother did intentionally supply prescription tramadol to her son. Unfortunately, her misleading initial affidavit delayed this investigation until, almost one year later, she provided the information to enable me to determine the source of the tramadol. It was this substance that played the most significant part in MB's death. Her failure to initially supply this important information may have, understandably, arisen from guilt, fear and grief. Nevertheless, MB was aware of her son's propensity to overdose on medication and that the tramadol was not prescribed to him.

I am satisfied that there are no suspicious circumstances surrounding MB's death. I am satisfied that the tramadol taken by MB was prescribed to either his mother or father, and provided to him by his mother.

It appears from the evidence in the investigation that MB ingested up to 8 capsules of alprazolam and 5 capsules of tramadol. It is unlikely that he had developed any tolerance to tramadol, having not previously been prescribed opioids. In this situation the resultant effects upon him were toxic.

I cannot rule out the possibility that MB intended to end his life by taking an overdose of medication. There was no evidence at all that he intended to do so, and his mood at the campsite was reported as being positive. The more likely scenario is that he took the excessive quantities of tramadol and alprazolam to relieve his anxiety without the intention of ending his life. However, I am unable to make a positive finding as to his intention in taking the medication.

Comments and Recommendations

This very sad case of the death of a young man highlights the proposition that prescription medications should never be shared. Prescription medications are classified as such because their use is non-trivial and may be inappropriate for use by persons for whom they were not intended or prescribed. Prescription opioids, such as tramadol, are particularly dangerous to share "off prescription" in part due to the phenomenon of tolerance.

Dr Ritchey, in his opinion, stated that "*tolerance is a physiologically complex phenomenon that is incompletely understood but well described in which the amount of drug needed (e.g. for pain relief) after repeat dosing increases. That is, with time, more drug is needed to relieve pain than when the drug was first taken. This is a particularly dangerous situation with opioid class drugs because the respiratory depressant effects of these drugs may not develop tolerance to the same degree as the analgesic effect. Therefore taking more drug to control pain may inadvertently cause respiratory depression and overdose. Similarly if a tolerant individual (say mother) instructed another person (e.g. son) of* ***her*** *dosing needs to control pain; that dose may be dangerous to an opioid naïve person causing overdose.*

Drug interaction is another common complication of drug sharing as appears to have occurred in this case. That is alprazolam (a benzodiazepine class drug) is a potentially dangerous combination with tramadol because both drugs cause CNS and respiratory depression by different pharmacological mechanisms such that their combined effect is potent, toxic and dangerous."

Thus, the death of MB illustrates the risks and possible tragic consequences of sharing restricted medications with persons to whom they have not been prescribed and have little tolerance.

I extend my appreciation to investigating officer Senior Constable Danny Jackson for his investigation and report.

The circumstances of MB'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 MDB.

Dated: 20 June 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner