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 Jacqueline Francis Koeter

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

a) The identity of the deceased is Jacqueline Francis Koeter.

b) Ms Koeter was born on 9 June 1962 and was 59 years of age at her death. She was not employed and lived with her adult daughter in Oakdowns. Ms Koeter suffered a serious anxiety disorder with panic attacks. She also suffered other health conditions including morbid obesity, chronic pain, osteoarthritis of the knees, insomnia and fatty liver. Ms Koeter was treated regularly by her general practitioner, Dr Peter Sexton, at the Clarence GP Super Clinic. At the time of her death she was prescribed alprazolam, a benzodiazepine, for over 30 years. Alprazolam is a known drug of dependence and, as a schedule 8 drug, its prescribing must be authorised by Pharmaceutical Services Branch (PSB). In the report from the last psychiatrist's review in March 2015, the psychiatrist reported to Dr Sexton that there was *"zero chance"* of Ms Koeter being able to transfer across from alprazolam to another form of treatment. From that time, PSB continued to approve her treatment with alprazolam.

Ms Koeter's daughter, Celine Koeter, was aware that often her mother misused her prescription alprazolam by taking more or less than the prescribed quantity. Although there is no evidence that Ms Koeter sourced alprazolam illegally, Celine said in her affidavit that her mother would on occasions take less than prescribed, thus saving additional tablets for the occasions when she felt that she needed them. Celine said that her mother was not able to leave the house without a significant quantity of medication to calm her. Celine said that the day following her mother having taken an excess of medication, she would be extremely tired.

Ms Koeter took an excess of medication on 28 September 2021 due to needing to leave the house for her second dose of the COVID-19 vaccine. The following morning, 29 September 2021, Celine tried to wake her but she only stirred lightly.

She appeared drowsy and pale. Celine decided to stay home from work that day as she wanted to be there when her mother woke up. She was clearly concerned about Ms Koeter's state and the effects of the medication. She continued to check her approximately every 15 minutes. At 10.30am Celine checked Ms Koeter's pulse and could not find it. She was also not breathing. Celine called for an ambulance. Ambulance paramedics arrived and, with extensive resuscitation efforts, obtained a return of circulation. Ms Koeter was transported to the Royal Hobart Hospital. However, due to her lack of oxygen whilst in cardiac arrest, she had suffered serious brain damage incompatible with life. She passed away on the same day.

c) The autopsy and toxicology testing revealed that Ms Koeter died as a result of global hypoxic brain jury due to the effects of mixed drug toxicity. Numerous prescription drugs were detected in her system. In particular, alprazolam was detected in her system within the reported fatal range. I am satisfied that there were no suspicious circumstances surrounding the circumstances of Ms Koeter's death and that she died unintentionally as a result of consuming an excess of alprazolam. Her other prescription drugs and morbid obesity contributed to her death.

d) Ms Koeter died on 29 September 2021 at the Royal Hobart Hospital Hobart, Tasmania.

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

- The police and hospital reports of death;
- Affidavits confirming life extinct and identification;
- Report of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Review By Dr Anthony Bell, coronial medical consultant;
- Ambulance Tasmania attendance records;
- Tasmanian Health Service records for Ms Koeter;
- General practitioner records for Ms Koeter from Clarence GP Super Clinic;
- Affidavit of Celine Koeter, daughter of Ms Koeter
- PSB report regarding prescribing to Ms Koeter;
- Photos of the scene depicting medication;
- Report from Dr Peter Sexton, general practitioner of Ms Koeter;
- Report of the coronial nurse concerning Ms Koeter's medical records; and

- Report from Rokeby Discount Drug Store.

Comments and Recommendations

Several issues regarding the prescribing of alprazolam to Ms Koeter were considered in this investigation. The main issues investigated were;

- The knowledge of Ms Koeter's general practitioner concerning her misuse of alprazolam, which placed her at significant risk;
- The length of time she had been prescribed this drug of addiction;
- The lack of specialist review of prescribing since the psychiatrist's review in March 2015; and
- Breaches by the general practitioner of PSB authorities to prescribe.

In relation to the above issues, I received a very helpful report from PSB. I also received reports from Dr Anthony Bell, Dr Peter Sexton and Mr Kevin Egan (coronial nurse, who reviewed the medical records).

In relation to the knowledge of the general practitioner regarding Ms Koeter's misuse of alprazolam, I am satisfied that the evidence indicates that Dr Sexton was not aware that she had been accumulating alprazolam by taking less than prescribed on some days and more than prescribed other days. I also accept Dr Sexton's report that Ms Koeter always presented at appointments well-groomed, not impaired and well-organised in relation to her medication regime. I also accept his report, after analysis of his records, that Celine did not tell him at any stage that Ms Koeter was misusing her medication. No criticism is to be made of Dr Sexton in this regard. He could not have foreseen that she would be at any particular risk of death by intentional overdose of alprazolam, given her apparent stability on the drug over many years and lack of warning signs.

In relation to the other issues, I am also satisfied that no criticism of Ms Koeter's general practitioner should be made. Dr Sexton reported on the difficulty in obtaining psychiatric review for Ms Koeter until 2015, when the review took place. Whilst subsequent review might have been desirable, the reality was that Ms Koeter would not have been able to cease or reduce her use of alprazolam for her panic disorder. I further note that her dose had remained stable over many years and that alprazolam may be used for the long-term treatment of panic disorder. In general, the rules and guidelines for the issue, prescription and review were fulfilled over the years since 2011 when Ms Koeter first attended the general practice. She had also been prescribed alprazolam in Queensland 20 years prior to that time. Although breaches were identified by PSB with regards to the issuing of authorities, Dr Sexton provided reasonable explanations. Although coroners have

commented on the significance and prevalence of prescribers prescribing without authorities, I am satisfied that there is no issue in this regard that may be connected to Ms Koeter's death.

The circumstances of Ms Koeter'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 Ms Koeter.

Dated: 1 May 2023 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner