



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 Marianne Steer

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

- a) The identity of the deceased is Marianne Steer;
- b) Mrs Steer died accidentally as a result of drug toxicity in the circumstances described in this finding;
- c) The cause of death is combined drug toxicity (methadone, diazepam, amitriptyline and mirtazapine); and
- d) Mrs Steer died between 23 and 25 September 2017 at West Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Steer's death. The evidence comprises the Police Report of Death, an opinion of the forensic pathologist who conducted the autopsy, toxicological results, family, police and witness affidavits and statements, information from Pharmaceutical Services Branch, medical records and reports and forensic evidence.

Background

Mrs Marianne Steer was born in Hobart on 20 April 1961. She was aged 56 years at the time of her death and was not in employment. Mrs Steer enjoyed a normal, happy childhood and a good education. Much of the following information regarding the course of Mrs Steer's life comes from the detailed affidavit of her daughter, Nikeisha Steer, whose account I accept as accurate.

When Mrs Steer was 22 years of age, she met Mr Phillip Steer. They travelled around Australia together on a Harley Davidson, with Mr Steer obtaining work in various jobs for short periods. They married and had three children together - Beau, (born in 1986 and passed away shortly after birth), James (born in 1987) and Nikeisha (born in 1991).

During the course of their relationship, Mrs Steer and Mr Steer were heavily involved in using illicit drugs, including heroin. Mrs Steer continued to use drugs, including injecting intravenously, whilst raising the children in Tasmania. For much of this time, Mr Steer worked

interstate as a civil engineer and would only return home to visit once every few months. Money sent home by Mr Steer to the family was largely spent by Mrs Steer on drugs as she had developed an addiction. In her affidavit, Nikeisha said that her older brother shielded her from the intravenous drug use by their mother and her associates occurring regularly in their home.

In 1992, Mrs Steer voluntarily sought help from Alcohol and Drugs Services (“ADS”). However the medical records indicate that she did not engage in follow-up treatment. In 1997 she again attended ADS and told the doctor that she was a heavy drinker. Her general practitioner at the time advised her to enter into a detoxification program with ADS but she did not wish to do so. In June and November 1998, Mrs Steer admitted herself to the detoxification unit at ADS. Despite these attempts at rehabilitation, the evidence indicates that Mrs Steer was unable to overcome her addiction to drugs and alcohol. The medical records also indicate that Mrs Steer likely suffered depression and anxiety and that she developed a dependence upon benzodiazepines.

At a time likely in the late 1990s, Mrs Steer and Mr Steer divorced but subsequently reconciled the relationship and the family relocated to Western Australia to accommodate Mr Steer’s employment. Mrs Steer began drinking alcohol heavily during this period.

In 2001 Mrs Steer returned to Tasmania with the children following the death of her brother. She and Mr Steer subsequently separated again. Mrs Steer and her children remained living in Hobart, moving to several different addresses over the following years. Nikeisha recalls that during this period her mother used “speed” and any other available drugs on a regular basis, that there were often other drug users at their home, and that there was inadequate money for food or paying bills.

Mr Steer returned to Tasmania and he and Mrs Steer reconciled the relationship once more. Nikeisha said that during this period both of her parents were using drugs heavily and that her mother abused the children emotionally, behaving erratically whilst under the influence of substances. Mr and Mrs Steer later separated for the final time. Subsequently, Mr Steer and James lived together and Mrs Steer lived with Nikeisha. In 2003 James returned to live with Mrs Steer and Nikeisha.

Mrs Steer tried to seek help to overcome her addiction. In 2001 she began to undertake the Tasmanian Opioid Pharmacotherapy Program (TOPP), involving regular dosing of methadone, under the supervision of Dr David Jackson. In the same year, she took an overdose of her prescription diazepam and was admitted to the Royal Hobart Hospital (“RHH”). She told treating doctors that this was a “cry for help” and stated that she was not coping with the death of her brother or her poor financial situation. As a result, Mrs Steer participated in the

Intake Program at ADS for several days and then discharged herself. She continued to refer herself to the ADS Intake Program under Dr Jackson on multiple occasions in 2002 and 2003.

In 2002 Dr Jackson withdrew from prescribing methadone and in 2003 Mrs Steer's general practitioner, Dr Richard Bourke, was given authority by the Pharmaceutical Services Branch to prescribe methadone in accordance with the TOPP. Mrs Steer remained on the TOPP, with Dr Bourke as the prescribing doctor, until April 2017.

It is clear upon the evidence that Mrs Steer continued to use illegally obtained drugs whilst participating in the TOPP. In 2008 Mrs Steer injected a substance which caused ischaemia in her left hand, resulting in amputation of four of her fingers.

In 2013 Mrs Steer was diagnosed with chronic obstructive pulmonary disease related to her drug use. She also smoked cigarettes. From 2016 until her death, she suffered a severe deterioration in this condition resulting in multiple presentations to the RHH for shortness of breath, difficulty breathing and respiratory infections. Mrs Steer's last admission to the RHH was in July 2017.

In April 2017 Mrs Steer had made contact with Dr Jackson (now at the Hobart Clinic) as she wished to withdraw from methadone. Her impetus for doing so was her desire to be 'clean' of all drugs in time for her son's upcoming wedding in Bali. She was last dispensed methadone by Dr Bourke on 17 April 2017. She was then treated by Dr Jackson between 18 April and 16 May 2017 with buprenorphine patches.

In June 2017, Mrs Steer began seeing a new general practitioner, Dr Rodney Davis. Dr Davis prescribed Mrs Steer medication for her chronic obstructive pulmonary disease and insomnia. At the time of her death Dr Davis had prescribed her Symbicort (for her shortness of breath) and diazepam for her insomnia.

Mrs Steer last attended Dr Davis on 6 September 2017 to discuss her intention to stop smoking and for a repeat prescription for Diazepam.

Circumstances of Death

On Saturday 23 September 2017, Mrs Steer's neighbour and friend, Mr Ricky Mundy, spoke to Mrs Steer as she was driving out of the laneway which connected their houses at the rear. In his affidavit for the investigation, Mr Mundy said that Mrs Steer appeared 'zonked' and worn out and told Mr Mundy that she had consumed a couple of bottles of 'done', meaning methadone. Mr Mundy expressed his concern to her about this and told her not to consume methadone again. Mrs Steer acknowledged this statement and then drove off. That evening, Mr Mundy's

partner, Ms Tanya Hoyle, noticed that unusually Mrs Steer's blinds were open and her light was turned on.

The following day, Sunday 24 September, Ms Hoyle, attempted to contact Mrs Steer by text message and attempted to call her mobile telephone. Mrs Steer did not answer the text messages and her phone appeared to be turned off, which was unusual for Mrs Steer. Ms Hoyle noted that Mrs Steer's blinds were still open and her light was still on.

On Monday 25 September Ms Hoyle remained unable to contact Mrs Steer and became concerned for her welfare. Therefore, at approximately 6.30pm Ms Hoyle attended Mrs Steer's property to check on her. She entered through the back gate, as was her usual means of visiting her residence. She knocked on the back sliding door but there was no answer. The door was unlocked which Ms Hoyle found unusual. Ms Hoyle entered the house. She called out but was unable to raise Mrs Steer. The television was on but the house was otherwise in order.

Ms Hoyle located Mrs Steer on her bedroom floor. She was lying on her left side, in a foetal position, at the foot of her bed. It was apparent that she was deceased.

Ms Hoyle returned to her residence and Mr Mundy called 000. Paramedics attended and confirmed that Mrs Steer was deceased.

Mrs Steer's body was transported by mortuary ambulance to the Royal Hobart Hospital. An autopsy was performed by the then State Forensic Pathologist, Dr Christopher Lawrence. At autopsy, Dr Lawrence noted multiple old and new needle marks and pill fragments in Mrs Steer's stomach. He also observed damage to Mrs Steer's lungs related to intravenous drug use.

Toxicological testing of blood samples taken at autopsy revealed the presence of methadone within the reported toxic range, as well as the presence of diazepam, amitriptyline, mirtazapine, melatonin and pregabalin. Forensic scientist, Ms Miriam Connor, relevantly stated in her toxicology report:

"From the literature it is clear that the primary mechanism responsible for methadone overdose deaths is respiratory depression. In combination with other central nervous system depressants (e.g. diazepam, amitriptyline, mirtazapine, melatonin, pregabalin) the respiratory depressant effects of methadone will be enhanced. It has been recognised that many cases of methadone-induced deaths are not attributable to methadone alone, but to the combined effects of methadone and another drug or drugs".

In Dr Lawrence's opinion, the cause of Mrs Steer's death was combined drug intoxication. Her pulmonary hypertension and damaged lungs also contributed to her death. I accept the opinion of Dr Lawrence regarding cause of death as well as the comments made by Ms Connor.

Police officers, including a forensics officer, attended and examined the scene. They found no signs of forced entry or suspicious circumstances. The officers located a number of prescriptions from her different doctors and prescription medications, as well as one empty methadone bottle. This bottle, representing a "take-away dose" of methadone for a person participating in the TOPP, had its label largely scratched off and therefore the identity of the prescribed recipient could not be determined. Paraphernalia associated with intravenous drug usage were also located in the bedroom and next to Mrs Steer. No note or communication expressing a wish to die was located in her bedroom or on her mobile telephone. Indeed, Mrs Steer appears to have wished to 'get clean' in time for son's wedding and was looking forward to this occasion.

I am satisfied, on the evidence, that Mrs Steer's death was accidental. She did not intend to end her life. I find that she unlawfully obtained a take-away dose of another person's methadone intended for oral consumption and injected it intravenously. It was this substance that was the major cause of her death. However, she had also taken other central nervous system depressants, as specified above, which were significant contributors to her death. Most of these medications appear to have been prescribed to her by her various treating doctors in the months before her death. I cannot, however, rule out that she also obtained some of these same types of medications unlawfully and ingested them before her death.

Comments

Comments about the scope of the investigation

The investigation into Mrs Steer's death has been comprehensive. The issues that have been examined in the course of the investigation are as follows:

- (a) The identity of the person (named in the investigation) who provided Mrs Steer with the take-away methadone dose prior to her death and whether there was a breach of the TOPP guidelines by any medical practitioner in prescribing takeaway doses of methadone to that person (thus allowing that substance to be misused);
- (b) Whether there was an adherence to the TOPP guidelines by Mrs Steer's treating doctors in respect of both her methadone and subsequent buprenorphine program, particularly in light of her known drug abuse; and

- (c) Whether the continued prescribing of diazepam to Mrs Steer by her treating doctors was appropriate in light of her use of methadone and severe lung condition.

After thorough consideration, I have decided not to investigate these issues further, nor to hold a public inquest. It is inappropriate in the circumstances to make further comment about them as they do not bear sufficient connection with the circumstances surrounding Mrs Steer's death.

Although the evidence allows me to suspect the identity of the supplier of the methadone, I am unlikely, even with further investigation, to be able to make such a finding to the requisite degree of proof. Moreover, that person died of natural causes shortly after the death of Mrs Steer, therefore further limiting the opportunity for investigation. Any issues surrounding non-compliant prescribing to that person by a medical practitioner are therefore also too remote for this investigation.

In respect of the potential issues surrounding possible non-compliance with TOPP guidelines and other treatment or prescribing decisions by Mrs Steer's own medical practitioners, again there is insufficient causative connection between such issues and her death. Ultimately, Mrs Steer sourced the methadone illegally and voluntarily, and engaged in the highly dangerous practice of injecting it intravenously, as she had done for many years in respect of this substance and other illicit drugs. Her own participation in the lawful methadone program had ceased at her request five months before her death.

Sadly, Mrs Steer suffered severe substance dependence and alcoholism for almost all of her adult life. Despite attempts at rehabilitation, including in the months before her death, she was unable to overcome her addiction.

General comments

Although I have chosen not to comment upon the specific issues referred to above for the reasons given, it is appropriate to make a general comment about the misuse of methadone takeaway doses, without criticising any medical practitioner or dispenser in this particular case.

Mrs Steer's death represents another case of take-away methadone being prescribed and dispensed as part of the TOPP, and then being diverted or misused and causing a death. Unfortunately, coroners encounter this scenario far too frequently. In many (but not all) cases of misuse of take-away doses, the recipient of the dose should have been dosed in the presence of an accredited pharmacist and not permitted to take it away.

The TOPP provides clear guidance to medical practitioners and pharmacists in respect to responsible prescribing and supply of takeaway methadone. Adherence to the TOPP guidelines is essential given the high rate of illegal diversion of prescribed take-away methadone doses. In summary, the TOPP guidelines specify that take-away doses may only be prescribed once a patient is medically assessed as clinically stable, able to safeguard that medication and take it as prescribed. Even then, there are numerous further restrictions on prescribing takeaway doses set out in the guidelines.

The basic premises from the guidelines is that methadone patients should consume their daily doses under the close supervision of an accredited pharmacist, with takeaway doses being the exceptional deviation from the TOPP and requiring documented clinical risk-benefit assessment and clinical input from the Alcohol and Drug Services.

I extend my appreciation to investigating officer, First Class Constable Michael Moore, for his investigation and report. I also greatly appreciate the assistance of the officers investigating the wider issues surrounding this matter, principally Senior Constable Kathryn Barwick, Senior Constable Tami Nelsen and First Class Constable Amanda Knight.

I make no recommendations pursuant to Section 28 of the *Coroners Act 1995*.

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

Dated 19 May 2020 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner