



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 Christopher Neil Adams

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

- a) The identity of the deceased is Christopher Neil Adams;
- b) Mr Adams died in the circumstances described in this finding;
- c) The cause of death is mixed prescription drug toxicity (methadone, fluvoxamine, tramadol, mirtazapine and diazepam) and advanced heart disease; and
- d) Mr Adams died on 28 February 2017 at Howrah, Tasmania.

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

Christopher Neil Adams was born in Hobart on 17 March 1985 and was aged 31 years at the time of his death. He was divorced and had four young children with his former wife. During the course of his life he was employed primarily as a labourer in roadside traffic control and demolition work.

At the time of his death, Mr Adams was living in Rosetta with his mother, Kim Adams, sister, Tayla Love, and brother, Shaun Love. For about a month before his death, Mr Adams had been in a relationship with Jenna Smith, who lived in Howrah.

Mr Adams suffered from depression, anxiety and insomnia. He also suffered from numerous physical ailments, including a shoulder injury in 2014 and a back injury in 2017, just before his death. He was a long-term and regular patient at the Richmond Medical Centre, mostly under the care of Dr Shaista Patel. The doctors' notes from the centre were obtained for this investigation. It is evident from these notes that Mr Adams had a history of abusing prescription medication and that he was addicted to opioid-based painkillers. The consultation notes indicate that Mr Adams related constant pain management issues to his doctor for the

purpose of seeking additional and / or alternative medication. Consultation notes from 2014 indicate that Mr Adams had a history of engagement with Alcohol and Drug Services in relation to codeine usage and that he was on an opiate reduction scheme. At that consultation he told his doctor that he had previously used cannabis, speed and “ice” but had recently ceased their use. Numerous other entries in the medical notes record Mr Adams as attempting to obtain additional prescriptions on the basis that he had lost his prescriptions or that they had been stolen or inadvertently destroyed.

Mr Adams’ medical records also show that he had difficulty coping with potentially traumatic events in his life and, in such situations, would attend his doctor seeking additional prescription medication to help him manage emotionally during difficult periods.

Mr Adams attended the Emergency Department of the Royal Hobart Hospital on four occasions between 2010 and his death as a result of ingesting excessive medication. On the last of such occasions, being 19 September 2016, Mr Adams was admitted to hospital in relation to a Tramadol (an opioid based analgesic) overdose and associated seizures. The discharge summary indicated that the overdose was accidental and not an attempt at self-harm on the part of Mr Adams.

Mr Adams’ treating doctors and dispensing pharmacists were aware of his drug-seeking tendencies and, it seems, attempted to appropriately limit his access to medication of addiction. Records were obtained from Pharmaceutical Services Branch (“PSB”) in this investigation. PSB is responsible for authorising prescription of Schedule 8 narcotic substances where patients have been declared drug dependent by a medical practitioner. PSB records reveal that it received numerous reports from health practitioners from 2010 onwards, reporting incidents of inappropriate drug seeking on the part of Mr Adams. On at least two occasions, circulars were generated by PSB and forwarded to pharmacists, Alcohol and Drug Services and Mr Adams’ treating practitioners, notifying them that he was a declared drug seeker.

On Monday 27 February 2017, Mr Adams drove to Ms Smith’s residence in Howrah, arriving at approximately 3.00pm. He and Ms Smith had previously arranged that he would spend the night at her house. In her affidavit, Mr Adams’ sister, Tayla Love, stated that before Mr Adams left for Ms Smith’s house, she intended to provide him with the medication he required for that evening and no more. She stated that his medication was stored in a locked safe for which Mr Adams did not have a key due to his history of abusing medication. Mr Adams had previously agreed to this practice about three years earlier, however, on this occasion he became angry and said that he wanted all of his medication. Ms Love stated that a big argument followed and

that she relented and provided Mr Adams with all of his medication. The medication included Valium, mirtazapine, Endep and likely Endone.

Ms Smith, in her affidavit for the investigation, stated that Mr Adams appeared to be his normal self at the time he arrived at her house and for the duration of his visit. She indicated that he did not appear at any time to be under the influence of drugs, nor was she aware of him using illicit drugs and / or drugs not prescribed to him whilst he was at her residence to her knowledge, apart from Viagra. Mr Adams only had with him medication she believed he was prescribed, being Valium and Panadeine Forte, which she believed was for his back pain.

Ms Smith said that she went to bed with Mr Adams at approximately midnight. At some stage she awoke and he was not in bed but she does not recall the time that this occurred.

At approximately 7.00am on Tuesday, 28 February 2017 she awoke and Mr Adams was in bed. She stated that he was snoring at this time and sounded congested. She closed the bedroom door, did some work around the house and then returned to the bedroom at approximately 10.15am. At this time she found Mr Adams in bed, laying on his right side and not able to be woken. He was unresponsive and his body was cold. She telephoned Ambulance Tasmania and administered CPR. When ambulance personnel arrived, they determined that Mr Adams was deceased.

Police officers arrived at the scene to investigate Mr Adams' death. They noted that no injuries were evident on Mr Adams' body and the circumstances of his death did not appear suspicious. They located a small pill bottle that Ms Smith identified as belonging to Mr Adams that, relevantly, contained Panadeine Forte and four Valium (diazepam) tablets.

On 1 March 2017 an autopsy was conducted upon Mr Adams by forensic pathologist, Dr Donald Ritchey. Dr Ritchey had regard to toxicological testing of a sample of Mr Adams' blood. The results indicated the presence of prescription medications fluvoxamine, tramadol, mirtazapine and diazepam and ibuprofen. It also identified a toxic level of methadone in his blood, being a substance that had never been prescribed to Mr Adams in Tasmania.

At autopsy, Dr Ritchey also observed that Mr Adams had a markedly enlarged heart, thickening of the left main chamber of the heart and widespread advanced narrowing of the coronary arteries supplying the muscle of the heart. Dr Ritchey formed the view that the cause of death was prescription drug toxicity with contributing factors being aspiration of gastric content, advanced coronary atherosclerotic vascular disease and obesity. Dr Ritchey stated in his report that the markedly elevated concentration of methadone, in addition to several other strong central nervous system depressants, in combination cause somnolence and stupor

during which time the normal reflexes for protecting the airway are diminished leading to aspiration and respiratory arrest followed by death. He further stated that obese individuals with advanced heart disease are at increased risk of death due to the central nervous system depressant effects of medications. Except for methadone, all of the drugs detected in analysis of Mr Adams' blood were either prescribed to him at the time of his death or had been prescribed to him in the past.

It does not appear that Mr Adams had a high tolerance to methadone. His history of illicit use of methadone is uncertain on the evidence, although there is no evidence to suggest he was a regular user of this drug and thus his tolerance to it was low. I find that ingestion of methadone was the primary cause of death.

Methadone is an opiate drug provided to opiate dependent patients as part of an opiate reduction program. It is prescribed by general practitioners to patients who are dosed at particular pharmacies under supervision. The relevant guidelines (the "TOPP guidelines") for methadone prescribing allow for limited "take-away" doses to be given to patients where, for example, a patient is not able to access a pharmacy at certain times. It is well-known that patients misuse the take-away dose system by selling their methadone take-away doses to other non-patients.

Whilst there is no question that Mr Adams ingested the methadone voluntarily, significant efforts in this investigation have been made to ascertain who supplied it to him. At the time of his death, one Shane Fazackerly was living temporarily in Rosetta with Mr Adams, his brother, sister and mother. Mr Fazackerly was a particular friend of Mr Adams' brother and was participating in the methadone program. In his police interview for the coronial investigation, Mr Fazackerly acknowledged that he was prescribed take-away doses of methadone by his doctor, with three take-away doses per week as the usual quantity.

Ms Smith said in her affidavit that, about a week before Mr Adams died, he arrived at her house under the influence of drugs, stating that he had swapped some of his prescribed Valium with a friend named "Shane" for a dose of methadone to manage his back pain. In his interview, Shane Fazackerly said that about three weeks before Mr Adams' death one of his take-away doses of methadone was missing and he presumed that either Mr Adams or his brother had stolen it from him. He also said that a few months before Mr Adams' death he and Mr Adams were travelling in a vehicle with Mr Adams driving. Mr Fazackerly said that at some stage into the journey, he went to sleep and, when he awoke, Mr Adams told him that he had consumed approximately one third of a bottle of Mr Fazackerly's take-away methadone dose whilst driving.

In his affidavit, Mr Shaun Love, Mr Adams' brother, said that he had been present on four or five occasions when Mr Fazackerly provided Mr Adams with methadone or swapped methadone for Mr Adams' medication, usually Valium. This evidence is plausible, however I do not intend to make a finding as to its accuracy. Ultimately, I cannot determine that Mr Fazackerly provided Mr Adams with the dose of methadone that caused his death. Mr Fazackerly's position is that during the days leading up to Mr Adams' death he noticed that his methadone doses were being watered down and concluded that Mr Love or Mr Adams had been stealing his methadone. He did not, however, speak to them about this.

I find that, before his death, Mr Adams illicitly obtained a take-away dose (or doses) of methadone from another person and, with little tolerance to the substance, ingested it with other prescribed central nervous system depressants. With his pre-existing heart disease and obesity, he died. I am satisfied that he did not intend to take his life but that his death was accidental. Unfortunately, his addiction to medication was not something he could overcome.

Comments

Mr Adams' death at a young age highlights the consequences of the misuse of prescribed take-away doses of methadone. The methadone consumed by him causing his death must have been prescribed as a take-away dose by a doctor to a person participating in the methadone program. Although I cannot comment about whether the take-away dose was appropriately prescribed, it is pertinent to make the following comments directed at medical practitioners.

The Tasmanian Opioid Pharmacotherapy Program Policy and Clinical Practice Standards ("TOPP guidelines") provides clear guidance to medical practitioners and pharmacists about responsible prescribing and supply of take-away doses of 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 take-away doses set out in the guidelines.

The basic premise underpinning the TOPP guidelines is that methadone patients are to consume their daily doses under the close supervision of an accredited pharmacist, with take-away doses being exceptional. Deviation from the TOPP guidelines requires a documented clinical risk-benefit assessment and clinical input from Alcohol and Drug Services. Consistent departures from the guidelines by medical practitioners who inappropriately prescribe take-

away doses increases the risk of harm and deaths in the community due to misuse and diversion.

If a doctor or pharmacist requires any information about appropriate prescribing of take-away doses of methadone, he or she should make contact with Alcohol and Drug Services.

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

I am grateful to Constable Douglas McKinlay, investigating officer, for his thorough investigation and report.

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

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

Olivia McTaggart
Coroner