



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 Conor Maclaren Evans

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

- a) The identity of the deceased is Conor Maclaren Evans;
- b) Mr Evans died accidentally as a result of ingesting illicit methadone and diazepam;
- c) The cause of death is mixed drug toxicity (methadone and diazepam); and
- d) Mr Evans died on 10 July 2018 at Hobart, Tasmania.

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

Conor Maclaren Evans was born on 16 April 1999 and was aged 19 years at the time of his death on 10 July 2018. His parents are Paul Leonard Evans and Karen Leslie Evans. He has a brother, Alexander Evans. Mr Evans' parents separated in 2007. Although the evidence indicates that he found it difficult to deal with their separation, both parents remained involved in his life and supportive of him. Throughout school, Mr Evans was physically active, participating in athletics and rugby. According to his friends and family, he was happy and social during his school years. His family and friends describe him as a genuine and caring person.

Mr Evans left school before completing grade 11. In his affidavit, his father stated that, during this year he began experimenting with drugs and started to lose interest in sport. He obtained several short-term labouring jobs but these did not continue due to his poor attendance. He was unemployed for approximately 12 months before gaining employment as a labourer for DDM Civil in February 2018. However, in the weeks leading up to his death his employer reduced his hours and stopped giving him work. It appears that Mr Evans' attendance at work was poor due to his mental health and drug use.

Mr Evans commenced smoking cigarettes in high school and, according to friends, he smoked one packet of cigarettes per day. He also started to smoke cannabis in high school but did not

continue using it. His friends have stated that Mr Evans took other drugs regularly from about the age of 17 years, including OxyContin, codeine, Valium, MDMA (ecstasy), cocaine, speed and sleeping pills.

Mr Evans suffered from regular headaches from the age of about 14 years, which his mother attributed to the consequences of concussion sustained in a game of rugby. He also suffered from a chronic cough that was particularly severe in the year before his death. It is apparent from the affidavit evidence of those close to him and his doctor's records that he had suffered from bouts of anxiety from a very young age. Although he told his doctor that he did not have thoughts of self-harm, he did make occasional comments to two of his close friends that he thought about suicide. I am satisfied, however, that before and at the time of his death he was in a positive mood and did not consider deliberately ending his life.

Mr Evans' last consultation with his general practitioner before his death was on 13 June 2017 at which Dr Richard Bryant prescribed him Zoloft for his anxiety. Mr Evans did not attend subsequent scheduled consultations with Dr Bryant on 10 August 2017 and 11 August 2017. Dr Bryant made contact with Mr Evans' father and advised that he did not attend the appointments.

The evidence as a whole indicates that Mr Evans did not take care of his health. Apart from his heavy smoking, his diet was poor and included quantities of fast food, caffeine and energy drinks. His friends also describe his addiction to a range of prescription and illicit drugs.

On 9 July 2018 Mr Evans spent time with his friend, Wayde Ulberg, at Mr Ulberg's home in Cambridge. Whilst Mr Evans was with Mr Ulberg, he asked Mr Ulberg if he could "*snort some lines in the kitchen*". Mr Ulberg allowed him to do so. In his affidavit for the investigation, he stated that he was concerned about Mr Evans' regular drug taking and he had previously told him that he did not like his drug use. Mr Ulberg said he heard Mr Evans on the phone talking to a person who he believed was Ned Alexander Howe. He heard Mr Evans ask the person he believed to be Mr Howe if he could collect some drugs but he did not hear what type of drugs were the subject of the discussion.

That afternoon, Mr Evans left Mr Ulberg's home. Mr Ulberg stated in his affidavit that he believed Mr Evans was intending to go to Mr Howe's home in Sandy Bay to collect the drugs. In this investigation, persistent attempts were made by police investigators to have Mr Howe provide relevant information for this investigation, however he declined to assist. The investigating officer, Constable Diana Callahan, noted in her report to me that police

intelligence holdings support the proposition that Mr Howe is involved in the supply of illicit drugs. There is therefore no evidence of the actual supply of drugs to Mr Evans that day.

At about 5.00pm on the same day Mr Evans collected his girlfriend, Ieshia Eastley from her work and dropped her at her mother's house in Rokeby. He then went to the Sandy Bay house of his friend, Liam James, arriving at about 7.00pm. Two other friends were there at that time. Drugs were not used by persons at the house. In his affidavit, Mr James said: *"I'd never seen Conor so messed up, he was slurring his words and nodding off. He appeared obviously drug affected. His eyes were droopy and all his movements and reflexes were really slow. Conor told me (sic) had taken drugs, some sort of opiates. He hadn't been drinking alcohol. We tried to make him stay that night, but he wouldn't and drove home."*

Mr James also stated that Mr Evans did not take any drugs at his house, and left between 10.30 and 11.00pm. It is likely that Mr Evans left Mr James' house at an earlier time, although this is not a significant matter. Mr Evans then drove home to Lindisfarne, where his father and stepmother lived. It is likely that he arrived at about 9.00pm. Mr Paul Evans stated in his affidavit that when his son arrived, he spoke to him and he noticed that his speech was slower than usual but he was also more talkative than normal. Ms Eastley was present at the home and both she and Mr Evans went to bed. It is likely that they went to bed at about 10.00pm. Ms Eastley said that Mr Evans did not appear to be under the influence of drugs, although she said that, as they were going to bed, Mr Evans told her that he had vomited and felt very sick. When they went to bed, they talked for some time before falling asleep.

When the alarm sounded at 7.00am, Ms Eastley saw that Mr Evans was not moving and shook him by the leg. She could not rouse him and noted that he was cold to touch. She sought help from Mr Evans' stepmother, who commenced CPR on Mr Evans. Ms Eastley called for an ambulance to attend. Mr Evans was not breathing and did not have a pulse at that time. Ambulance paramedics attended and worked on Mr Evans whilst transporting him to the Royal Hobart Hospital. Tragically, he could not be resuscitated and was declared deceased by a doctor at 8.13am on 10 July 2018.

Police officers attended the Lindisfarne address and commenced an investigation into Mr Evans' death. They found three empty diazepam blister packets. Various Panadol medications were also found.

An autopsy was performed upon Mr Evans by forensic pathologist, Dr Donald Ritchey. In his report, Dr Ritchey noted that there was no apparent anatomical cause of death. Dr Ritchey had regard to the results of toxicological testing of Mr Evans' blood which indicated the

presence of methadone, diazepam and paracetamol. Dr Ritchey expressed the opinion that Mr Evans died as a result of mixed drug toxicity caused by the ingestion of methadone and diazepam.

Dr Ritchey stated in his report that methadone is a synthetic opioid that is used to treat opiate dependence and withdrawal, whilst diazepam is a benzodiazepine used as an anxiolytic and hypnotic drug to induce sleep with a long duration of action. He stated that both diazepam and methadone are significant central nervous system depressants that cause sedation, sleep and unconsciousness by different pharmacological mechanisms such that the combined effect of the two medications is greater than the sum of the two medications alone. He reported that the combination of benzodiazepines and opioid drugs is especially dangerous because of the enhanced respiratory depression leading to respiratory arrest and cardiac arrest. In the case of Mr Evans, Dr Ritchey stated that he likely suffered a cardiac arrest during sleep, although the interval of that arrest is unknown. I accept the conclusions of Dr Ritchey regarding the cause of Mr Evans' death.

In conclusion, Mr Evans was a regular user of illicit substances and illicitly obtained prescription medication. In the afternoon of 9 July 2018 he purchased diazepam and methadone from an illicit supplier. Mr Evans had never been prescribed these substances and it is unclear on the evidence the extent of his previous use of or tolerance to them. I cannot determine the quantities ingested, although the two blister packs of diazepam were empty. There is insufficient evidence to make a positive finding that the supplier was Ned Alexander Howe. A thorough examination of telephone records has not been able to advance this issue and Mr Howe declined to supply any information to police.

I am satisfied that the death of Mr Evans was accidental in nature.

Comments and Recommendations

I have decided not to hold an inquest into the death of Mr Evans for the purpose of considering the issue of supply of the substances to Mr Evans. I am satisfied that Mr Evans purchased and ingested the substances of his own free will. However, I comment that the person or persons who supplied him with the illicit substances have taken advantage of his addiction and vulnerability for personal profit. Those substances were the cause of his death.

Mr Evans was 19 years of age and too young to die. His death is heartbreaking for his family and those close to him, and has no doubt affected many in his wider circle.

Accidental deaths of young people by illicit drugs is something of great concern to our community. I intend to publish this finding in the hope that it may prevent even a few from taking the risk of using illicit drugs, the effects of which cannot be accurately predicted and may result in death. Perhaps some of those supplying such drugs may also reconsider their actions in light of the potential consequences.

I extend my appreciation to investigating officer Constable Diana Callahan for her thorough investigation and report.

The circumstances of Mr Evans' 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 Mr Evans.

Dated: 18 February 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner