



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 9th day of June 2011 and the 3rd day of September 2013, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Shane Andrew Kromwyk.

The said Court finds that Shane Andrew Kromwyk aged 38 years, late of 7 Florence Crescent, Brompton, South Australia died at Brompton, South Australia on the 14th day of March 2009 as a result of mixed drug toxicity and arrhythmogenic right ventricular dysplasia. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

- 1.1. Shane Andrew Kromwyk died on 14 March 2009. He was 38 years of age. He died at the premises at which he was residing pursuant to home detention bail conditions. A post-mortem examination of his remains revealed that his cause of death was mixed drug toxicity and arrhythmogenic right ventricular dysplasia. Arrhythmogenic right ventricular dysplasia was a pre-existing condition of Mr Kromwyk's heart that as far as is known had not been diagnosed during his life. Although this condition may have contributed to Mr Kromwyk's death, the principal cause of his death was mixed drug toxicity that was represented by the presence in his blood of the drugs methadone, diazepam, nordiazepam (a metabolite of diazepam and not separately consumed) and alprazolam. There were traces of the drug commonly known as GHB in Mr Kromwyk's post-mortem blood sample. However, to my mind the deliberate ingestion of the substance has not been demonstrated having regard to the fact that the substance can occur naturally in the human body and that in this case the

concentration was consistent with that. As well, GHB was not found at the address at which Mr Kromwyk was required to reside pursuant to his bail conditions and there is no evidence that he had any other source of this substance.

- 1.2. The report of Forensic Science South Australia toxicologist, Ms Joanna Rositano¹, states that the level of methadone detected in Mr Kromwyk's post-mortem blood was '*a potentially lethal concentration depending upon previous drug history*'. The concentration of methadone combined with benzodiazepine such as diazepam and its metabolite nordiazepam is said to have possibly caused '*additive central nervous system and respiratory effects*'.
- 1.3. I find that the cause of death of Mr Kromwyk was as stated in the post-mortem report, namely mixed drug toxicity and arrhythmogenic right ventricular dysplasia. I find that the principal causative factor was the ingestion of the substances that I have described. For reasons that will become apparent it is clear that Mr Kromwyk consumed methadone in a quantity in excess of what was recommended and that this is reflected in the potentially lethal concentration in his blood sample. Although these substances appear to have been taken in excessive quantities, in particular methadone, there is no evidence from which a conclusion can be drawn that Mr Kromwyk deliberately took his own life. It appears that Mr Kromwyk died essentially from an overdose.
- 1.4. The substances in question had all been prescribed for Mr Kromwyk by different medical practitioners.
- 1.5. I have alluded to the fact that Mr Kromwyk was on bail at the time of his death. The type of bail in question was home detention bail. The relevant conditions of his bail were that he be subject to home detention and obey all the lawful directions of any supervisor designated to supervise home detention. It was a condition that he reside at 7 Florence Crescent, Brompton and not to absent himself from that residence except for the purpose of urgent medical or dental treatment or in other emergency situations unless prior approval to be absent from that address was given by a home detention supervisor from the Department for Correctional Services. Additional requirements were that he was not to consume or use any drug which was not medically prescribed or legally available and to submit to any urinalysis as directed. I have already alluded to the fact that the substances that contributed to Mr Kromwyk's

¹ Exhibit C3a

death had all been medically prescribed for him and thus, strictly speaking, his consumption of those drugs was not of itself a breach of his home detention bail conditions.

- 1.6. Mr Kromwyk died at the premises at which he was detained pursuant to home detention bail. Accordingly, this was a death in custody as defined by the Coroners Act 2003 and for that reason an Inquest into the cause and circumstances of his death was mandatory.

2. Background

- 2.1. Mr Kromwyk had suffered from anxiety and depression for large periods in his life. He had sought the assistance of various prescription medications to help him with these disorders. There is evidence that at one time in the past Mr Kromwyk had suffered from heroin addiction for which he had been prescribed methadone. Mr Kromwyk had a criminal history that included drug related offences which the investigating SAPOL officer believes were the subject of cannabis expiation notices. Although there appears to have some legitimacy in Mr Kromwyk's consumption of prescription medications, it is said that he was an occasional abuser of the same.
- 2.2. The prescription drugs that Mr Kromwyk was said to have abused from the early 1990s included serapax and valium. A Community Corrections report compiled in 1996 asserted that Mr Kromwyk was in the habit of attending several doctors to obtain that medication. The same report describes a heroin addiction for which Mr Kromwyk was placed on the methadone program in February 1996. While I do not understand there to be a suggestion that the heroin addiction at that time was anything other than true, Mr Kromwyk's general history of consumption of prescription medication suggests that at times he would consume such medication indiscriminately and on occasions in a mixture. It is also apparent that although Mr Kromwyk from time to time consumed illicit drugs such as cannabis and amphetamines, he had a preference for prescription medications.
- 2.3. The alleged offences in respect of which Mr Kromwyk was on remand were not drug offences. They involved allegations involving domestic violence. These matters had not been completely resolved in the courts at the time of Mr Kromwyk's death.

- 2.4. During the currency of Mr Kromwyk's bail he was subjected to a number of random urinalysis tests, based for the most part on suspicions of Department for Correctional Services' caseworkers that Mr Kromwyk was consuming illicit substances. The tests were undertaken in 2008 and early 2009. A test on 11 February 2009 revealed the presence of methadone and amphetamines. At that time Mr Kromwyk was not on the methadone program and it therefore could not be regarded as a prescribed medication. Amphetamine is an illicit substance per se. Mr Kromwyk's consumption of both substances, as revealed by urinalysis, was thus in breach of his bail conditions. These tests involved notification to South Australia Police and the last of these tests resulted Mr Kromwyk being 'breached' in respect of his bail. Mr Kromwyk was arrested on 21 February 2009 and was remanded in custody until 4 March 2009. He pleaded guilty to breach of bail and on 4 March 2009 he was released back into the community on home detention bail in respect of the original domestic violence charge. The conditions of his bail were the same as before and no doubt it would not have been lost on Mr Kromwyk that he might be the subject of further random urinalysis.
- 2.5. From time to time Mr Kromwyk consulted Dr Nicholas Williams at The Parks Primary Health Care Services. The first consultation occurred in May 2004 when Dr Williams continued Mr Kromwyk on the buprenorphine program which he had been placed on by another practitioner in respect of drug addiction. Dr Williams was also aware that Mr Kromwyk took diazepam which had been prescribed by another doctor. Dr Williams provided a statement to the Inquest². In that statement he explains that in the end Mr Kromwyk voluntarily ceased taking buprenorphine and that this occurred sometime after 30 September 2007 when Dr Williams last prescribed it. That date was the last time Dr Williams saw Mr Kromwyk until 20 February 2009 when Mr Kromwyk presented and stated that he had again developed a heroin addiction and requested that he be placed on the methadone program. It will be noted that this appointment occurred within a few days of his positive test for methadone, the consumption of which was in contravention of his bail conditions unless prescribed which it was not. Dr Williams states that to begin with he prescribed methadone at 40mg per day. From the following day, 21 February 2009, which was the day of his arrest for breach of bail based on his positive urinalysis, Mr Kromwyk would remain in custody until his release on 4 March 2009. Dr Williams states that he next saw Mr Kromwyk again on 10 March 2009. Mr Kromwyk told him that he had been in the

² Exhibit C15a

Adelaide Remand Centre for breach of bail. Mr Kromwyk was again restarted on the methadone program at 40mg per day which was altered on the following day, Wednesday 11 March 2009, to 55mg per day after discussions with Mr Kromwyk about the dosage.

- 2.6. Dr Williams again saw Mr Kromwyk on 12 March 2009 which was a Thursday. In accordance with the usual arrangement, Mr Kromwyk would collect the methadone on a daily basis from a pharmacy, in this case Gordon's Pharmacy at 215 Torrens Road, Croydon. This pharmacy filled the prescriptions in February 2009 at 40mg. Mr Kromwyk filled the further prescriptions beginning in March 2009 at the same pharmacy. On 11 March 2009 the pharmacy furnished Mr Kromwyk with a dose of methadone. The pharmacy also furnished him with a dosage on Friday 13 March 2009. I am not certain about a dose on 12 March. In any event, as I understood the evidence the daily doses were administered at the pharmacy by pharmacy staff so that Mr Kromwyk could be seen to consume them while there. For the weekend of Saturday 14 March and Sunday 15 March 2009, Mr Kromwyk was provided with two diluted 'takeaway' methadone bottles for his unsupervised self-administration on each of those days.
- 2.7. Although there was some prior history of heroin consumption and addiction in respect of Mr Kromwyk's drug issues, there is little or no evidence to suggest that Mr Kromwyk was addicted to heroin in February and March 2009. It appears that Dr Williams accepted Mr Kromwyk's unsupported assertions in that regard. Having regard to the fact that Mr Kromwyk had tested positively for non-prescribed methadone in contravention of his bail conditions, there is naturally reason to believe that his asserted heroin addiction and supposed need for prescription methadone was a device calculated to legitimise his consumption of methadone were he again to be tested positively in respect of that substance in the future. There is no evidence that Dr Williams appreciated any of this.
- 2.8. Mr Kromwyk had obtained diazepam from Dr Malcolm Nancarrow of the Alberton Medical Clinic on 10 January, 7 February and 7 March 2009. This was prescribed for him in order to help him sleep. Dr Nancarrow had seen Mr Kromwyk as a patient since 2002.
- 2.9. Mr Kromwyk obtained alprazolam from Dr Donald Angus at the Health on Grange Clinic at Flinders Park. Mr Kromwyk had first consulted with Dr Angus in December

2008. He told Dr Angus that he had been released from prison, that he did not have any alprazolam and needed a prescription for this. He said that he had been prescribed that drug whilst in prison. Dr Angus prescribed him alprazolam 2mg, one tablet twice a day and there were 50 tablets in that prescription. He next saw Mr Kromwyk on 13 March 2009, the day before the latter died. On that occasion Mr Kromwyk indicated that he needed a repeat of his previous alprazolam medication. This was then prescribed in the same amount as his previous prescription from December 2008.

- 2.10. It does not appear that any of these medical practitioners were aware of the fact that Mr Kromwyk was seeing other doctors for prescription meds and effectively doctor shopping.
- 2.11. It is clear that the Department for Correctional Services officers were aware of Mr Kromwyk's attendances to obtain methadone. An entry in his casenotes³ dated 20 February 2009 refers to a home visit from one of his caseworkers and records that Mr Kromwyk had a permanent pass for Mondays to Saturdays to allow his daily attendances at Gordon's Pharmacy to be administered with methadone, noting that Mr Kromwyk obtains 'takeaway' for Sundays. There is also reference to approval being given for Mr Kromwyk to attend the Alberton Medical Centre. This entry is dated 8 March 2009 following Mr Kromwyk's release from the Adelaide Remand Centre. An entry dated the same day refers to a pass being approved for him to attend The Parks Clinic to recommence the methadone program and records:

'Shane advised he has decided to recommence methadone in a firm attempt to help with substance abuse.'

There are further entries relating to passes to attend at The Parks Clinic on 10 March 2009 and 12 March 2009 and there is reference to an ongoing pass Monday to Friday in an entry dated 13 March 2009. In addition, there is reference to a pass being approved for Mr Kromwyk's attendance on Dr Angus at the Flinders Park Clinic for 13 March 2009 on the understanding, as apparently reported by Mr Kromwyk, that he had fallen over in the shower and thought that he had sprained his wrist, a matter that does not appear to have formed any part of Dr Angus' consultation on 13 March 2009 which, as seen earlier, related to the obtaining of alprazolam. In the same DCS entry dated 13 March 2009 there is a reference to Mr Kromwyk being provided with a pass

³ Exhibit C26k

for Sunday 15 March 2009 in order to collect his son for access purposes which indicates that Mr Kromwyk had plans beyond 14 March 2009, the date of his death. This is relevant to the question as to whether or not Mr Kromwyk deliberately took his own life and signifies to my mind that he did not have such an intention when he overdosed on his medication.

- 2.12. Mr Kromwyk's attendances on different medical practitioners was known to, and authorised by, the Department for Correctional Services. In particular it was clearly known to the Department that Mr Kromwyk was consuming methadone pursuant to a doctor's prescription. The legitimacy or otherwise of Mr Kromwyk's being on the methadone program on the basis of a reported heroin addiction does not appear to have been the subject of Departmental scrutiny. However, it is clear that Mr Kromwyk had been addicted to heroin in the past and that it would therefore not be wholly unreasonable for Department officers to conclude that his being placed on the methadone program by a medical practitioner did not need to be questioned. That said, others may well have seen through Mr Kromwyk's ploy.

3. The circumstances of Mr Kromwyk's death

- 3.1. As alluded to earlier, Mr Kromwyk resided at 7 Florence Crescent, Brompton pursuant to his bail conditions. This was the premises occupied by his mother and her partner. It is apparent that Mr Kromwyk occupied the lounge room of the premises. At about 9pm on the evening of Friday 13 March 2009 Ms Christine Kromwyk, Mr Kromwyk's mother, spoke to her son in the lounge room of the premises and noted that he was in a buoyant frame of mind as he had obtained permission to see his son that weekend. At 9am the following morning Ms Kromwyk observed Mr Kromwyk to be asleep on a chair and to be snoring. At about 11:30am she checked on her son and noticed that he was still snoring but was on his side on the floor. At about 1:40pm she could not hear Mr Kromwyk snoring and became concerned for his welfare. She went to the lounge room where he was still lying on his side but was unresponsive. He was deceased. An ambulance attended and he was declared life extinct.
- 3.2. Police attended at the address and conducted investigations. Police found a number of items of interest including a small amount of cannabis, unused syringes, a water bong and a ceramic bowl containing a brass pipe and a small amount of cannabis. It was

established that in addition to the methadone dose that he had consumed under supervision at Gordon's Pharmacy on 13 March 2009, Mr Kromwyk had consumed all of the two 'takeaway' methadone bottles except for a quarter of one bottle. This explains the potentially lethal concentration of methadone in his post mortem blood analysis. As well, he had obviously consumed alprazolam tablets and diazepam medication.

- 3.3. I have referred to the presence of cannabis at the premises. Although there were also unused syringes located, there was no indication that Mr Kromwyk had been consuming heroin on the premises.

4. Conclusion

- 4.1. It appears that Mr Kromwyk was an accomplished doctor shopper and manipulator when it came to securing Department for Correctional Services permission to attend doctor's appointments and pharmacies in order to obtain prescription meds in respect of which he had no demonstrated legitimate clinical need. It has not been necessary to make any formal recommendation in this matter, but the lesson to be learnt from this case is that it would be as well for Department for Correctional Services caseworkers to view the actions of clients who seek permission to habitually attend doctor's appointments and pharmacies, especially those with a history of drug and medication abuse, with the appropriate measure of scepticism.

5. Recommendations

- 5.1. The Court does not see the need to make any recommendations in relation to this matter.

Key Words: Death in Custody; Drug Overdose

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 3rd day of September, 2013.

Deputy State Coroner