MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to S.57(1)(c) of the Coroners Act 1995.)

I, Stephen Carey, Coroner, having investigated the death of the deceased

Find That:

a) The identity of the deceased is Mr R;

b) Mr R died in the circumstances described in this finding;

c) Mr R died as a result of combined drug (doxepin, mianserin and fluoxetine) intoxication; a contributing factor was hypertensive heart disease;

d) Mr R died in June 2014 in Southern Tasmania; and

e) Mr R was born in Queensland in 1953 and was aged 61 years; he was a married man and a retired electrical engineer at the date of his death.

Circumstances Surrounding Death:

Mr R was married to Mrs R for 36 years and they had three children. Mr and Mrs R lived together at their residence in Southern Tasmania. However, due to Mr R's snoring, they had been sleeping in separate rooms.

Mr R was a patient of a local medical practice since May 2007 and had a history of depression which his wife says was suffered for around 18 to 20 years. In May 2007, he was prescribed fluoxetine and doxepin for depression and lumiracoxib for arthritis that he suffered in relation to his knees. Shortly after this prescribing he advised that he ceased taking the fluoxetine.

In 2011 Mr R reported symptoms of major depression which had developed after he had ceased taking his doxepin. He was prescribed with desfenlafaxine for his depression and appeared to improve in the weeks after that visit. In 2012 his medication for depression was changed from desfenlafaxine to mianserin. In March 2013 his prescription for mianserin continued and his treating general practitioner at the time, Dr Magraith, was not aware that he was taking any other medication for his depression.

In July 2013 Mr R again saw Dr Magraith, reported feeling “flat” and discussions were held regarding whether or not to change his medication. It was decided, however, in another attendance in October 2013 to continue with the mianserin.

From a cardiovascular point of view, Mr R was noted to have high cholesterol in 2010 and was treated with lifestyle advice and statin tablets. In July 2013 he was diagnosed with hypertension and treatment was commenced. On an attendance of 11 February 2014 he was noted to have a slightly elevated fasting blood sugar reading and arrangements were made to further investigate this issue. Dr Magraith recalls being concerned at that time about Mr R’s high cardiovascular risk because of multiple risk factors – over weight, hypertension, high lipids and possibly diabetes.

Mrs R indicates that it was usual for her husband to drink alcohol daily; however this was not reported to be to an excessive level. He did consume alcohol during the day before his death, however the toxicology report post-mortem does not report alcohol present in his blood.

On the day before his death, Mr R attended a chemist in order to fill his prescription for his cholesterol medication. He reported to his wife at that time that he did not require a further issue of his anti-depressant medication. After returning home he washed his car and then spent the afternoon watching the football. His wife spent the afternoon reading in another part of the house and at 7:30pm noted that Mr R was lying on his bed, fully clothed. She enquired as to whether he wished to have anything for dinner to which he merely grunted. She advised him if he wanted dinner it would be downstairs for him. Mrs R, at about 8:00pm, heard her husband go to the toilet. She was, at that time, downstairs in the house and he was using the upstairs toilet. At approximately 12:10am she went to bed and not long after this she, once again, heard her husband use the toilet and go back to bed.

The next morning at 10:00am, Mrs R woke and realised that she had slept in. She looked for her husband as she also noted that their dog was inside which was unusual as Mr R normally lets him out of a morning when he goes out to get the newspaper. She found her husband lying on his side on the bed. She was unable to rouse him; she felt that he was cold and immediately called Tasmanian Ambulance Service. Records from Tasmanian Ambulance Service note that a unit was dispatched at 10:03am and arrived at the scene at 10:10am. The paramedic reports that Mr R was found lying prone with his legs over the side of the bed, post-mortem lividity and rigor mortis was present, he was cold to touch and had no carotid pulse. Given the findings and preliminary assessment resuscitation endeavours were not commenced.

A post-mortem was conducted by State Forensic Pathologist, Dr Christopher Lawrence, who reports that this revealed that Mr R had an enlarged heart (544gms) probably due to hypertensive heart disease, but there was no ischaemic heart disease. Some pill fragments were located in the stomach. The post-mortem toxicology revealed a blood level of tricyclic anti-depressant doxepin at a level reported in the fatal range, fluoxetine in a level greater than therapeutic range and a therapeutic level of the anti-depressant mianserin. The report from the

forensic scientist who conducted that toxicology assessment notes that doxepin has been reported to undergo post-mortem re-distribution; that is, the blood concentration of the drug after death is higher than the blood concentration at the time of death and the concentration tends to increase with increasing post-mortem interval.

Tragically, Mr R appears to have self-medicated on prescription anti-depressant medication that he had been prescribed over previous years. This may have been as a result of his reported deterioration of depressive symptoms in the period leading up to his death, which he has sought to address by taking previously prescribed medication. Unfortunately, he has not realised the inherent danger of taking the multiple anti-depressant medication. Although Mr R was suffering depression there is no indication at all that he has consumed this medication with an intent to self-harm. Mrs R reports that they were planning a holiday overseas in August of that year and in addition Mr R was excited not only about that trip but the pending birth of a granddaughter. Mr and Mrs R had planned to go to the mainland for this birth soon after they returned from their overseas holiday.

Comments and Recommendations:

This tragic event highlights the danger that can arise where prescription medication is taken other than in accordance with expert direction. I would recommend that medical practitioners who are prescribing anti-depressant medication over an extended period where there are changes in the nature or type of such medication ensure that their patient destroys any unused prior prescription, and that patients generally are made aware of the dangers, including the risk of a fatal outcome should they mix such medication or take that medication at a level higher than the prescription directions.

The circumstances of Mr R's death are not such as to require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

I wish to convey my sincere condolences to the family of Mr R.

DATED: 30th September 2015 at Hobart in the State of Tasmania.

Stephen Carey

CORONER