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 names of the parties by direction of the Coroner)

I, Olivia McTaggart, Coroner, having investigated the death of DS

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

a) The identity of the deceased is DS;
b) DS died in the circumstances described below;
c) The cause of death was ethanol (alcohol) and prescription drug toxicity; and
d) DS died between 19 and 20 July 2016 at New Town, Tasmania.

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

I make the following further findings.

DS was born in India on 22 August 1969 and was aged 46 years at the time of his death. He moved to Australia in 1999. In October 2005, he married SK and the couple lived together in Tasmania since that time. They resided in New Town. There are two children of the relationship. DS was employed as a taxi driver.

DS had a history of alcohol addiction. His medical records also show diagnoses of epilepsy and insomnia. From 2003, he saw his general practitioners on a regular basis for treatment for his alcohol addiction. He was treated with medications and attended counselling sessions.

SK stated in her affidavit for the investigation that DS would regularly consume a bottle of whiskey a day. In the three weeks prior to his death, SK reported that her husband began consuming even more alcohol, up to three bottles of whiskey a day. The evidence suggests that his increase in consumption may have partly been due to suffering pain from a recent finger injury.

At around 1.30pm on 19 July 2016, SK returned home after being at work for the day. Upon entering the home, she saw DS lying on his back on the floor in the dining area sleeping. She woke him and asked him to get up and go to bed but he stated that he was tired and wanted to stay where he was. SK stated that he appeared heavily intoxicated. An empty bottle of Jack

Daniels whiskey was beside him on the floor. SK stated that it was not unusual to find DS in this state when he had been consuming alcohol and, on these occasions, she would leave him where he was as he was too heavy for her to move.

At around 4.30pm, DS started coughing heavily. Their daughter asked him if he wanted to get up and go to bed but he stated that he was okay and would get into bed later. The daughter placed a blanket over DS to make him more comfortable.

At 8.30pm SK and the children went to bed. DS remained sleeping on the dining area floor.

At about 7.00am the following morning, 20 July 2016, SK discovered DS still on the floor of the dining area, although he was closer to the kitchen area than he was the previous evening. He was face down. She shook him to try to wake him but he did not respond. SK called their neighbour and close friend, PV, to assist. He arrived minutes later and attempted CPR upon DS, although he observed that DS appeared to have been deceased for some time. He called an ambulance, which arrived quickly. Ambulance officers determined that DS was deceased.

From 7.43am onwards police officers, including CIB and forensics officers, arrived at the scene and commenced an investigation into DS' death. They were of the opinion that there were no suspicious circumstances surrounding his death or that any other person was involved. There was also no suggestion that he had intentionally ended his life.

On 21 July 2016 forensic pathologist, Dr Donald Ritchey, performed an autopsy upon DS. He determined that the cause of DS' death was ethanol (alcohol) and prescription drug toxicity. In coming to his conclusion Dr Ritchey relied upon toxicological testing that indicated that DS' post mortem blood alcohol level was between 0.316 g/100ml and 0.482 g/100ml. Testing also detected the presence of diazepam and clonazepam, which were DS' prescribed medications. I accept Dr Ritchey's opinion as to the cause of death.

I find that DS consumed alcohol very heavily on a regular basis. Unfortunately, despite treatment, he was not able to overcome his addiction. In the weeks before his death his alcohol consumption increased further and, additionally, he was taking prescription medication for a finger injury. The combination of medication and alcohol (being central nervous system depressants), caused increased toxicity and, unfortunately, death.

Comments and Recommendations:

I extend my appreciation to investigating officer Constable Laura Windfeld-Petersen for her investigation and report.

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

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

Dated: 21 January 2019 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner