MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Derek William Arnold

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

a) The identity of the deceased is Derek William Arnold;
b) Mr Arnold died as a result of a drug overdose;
c) The cause of Mr Arnold's death was acute methadone toxicity; and
d) Mr Arnold died between 7 and 8 January 2019 at 387 New Country Marsh Road, Tunnack, Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Arnold's death. The evidence includes:

- The Police Report of Death;
- An opinion of a forensic pathologist;
- Records – Kingborough Medical Centre;
- Records – Queensland Health;
- Records – Correctional Primary Health Services;
- Report – Acting Chief Pharmacist, Tasmania;
- Affidavit of Mr Edward Lyden;
- Affidavit of Mr Daniel Arnold;
- Affidavit of Ms Elizabeth Arnold; and
- Forensic and photographic evidence.

Circumstances of Death

2. At about 4.00pm on 8 January 2019, in his bed covered with his blankets and doona, 51 year old Mr Arnold's body was found by his mother and stepfather. They contacted emergency services and, under the instruction of the operator, attempted CPR. Attending ambulance and police quickly determined because of the extent of *rigor mortis* that Mr Arnold was dead and had been for some time.

Investigation

3. The fact of Mr Arnold's death was investigated pursuant to the requirements of the *Coroners Act* 1995. His body was examined and photographed at the scene. The room in which his body was found was searched and various exhibits, principally a large amount of prescription medication, were seized. His body was formally identified and transported by mortuary ambulance to the Royal Hobart Hospital.

4. Nothing was found at the scene to give rise to any suspicion of the involvement of anyone else in Mr Arnold's death.

5. Nothing was found at the scene to suggest that Mr Arnold's death was suicide. Specifically, nothing in the nature of a suicide note or farewell letter was located in his room.

6. At the Royal Hobart Hospital, an autopsy was carried out by Dr Donald Ritchey, an experienced forensic pathologist. Dr Ritchey found that Mr Arnold's stomach contained partially digested fragments of solid material and a round fragment of aluminium foil inscribed "methadone". That aluminium foil fragment almost certainly came from a medication blister pack. I note that a methadone blister pack was located at the scene containing 6 tablets (with 4/10 having been used and in a box that had originally contained 20 tablets). No other methadone was located at the scene.

7. Samples were taken at autopsy and subsequently analysed at the laboratory of Forensic Science Service Tasmania. That analysis showed that Mr Arnold had 2.5 mg/L of methadone in his body at the time of his death - a level within the reported fatal range. Dr Ritchey expressed the opinion that given this finding and in the absence of any pathological cause of death being identified at autopsy, the cause of Mr Arnold's death was acute methadone toxicity. I accept Dr Ritchey's opinion as to the cause of Mr Arnold's death.

8. During the investigation, it became apparent that Mr Arnold was, at the time of his death, on bail for historic sex offences allegedly committed against one of his children in Queensland some years ago. It is no part of the role of a coroner to pass judgement on the truth or otherwise of those allegations. I note that they were, at the time of his death, just that – allegations. Nonetheless, undoubtedly allegations of that type (true or not) would certainly cause anyone distress.

9. Mr Arnold's medical history was complex and very sad. Due to chronic ongoing pain, he was first prescribed methadone in about 2011, while living in Queensland.

10. The first record of Mr Arnold receiving any medication in Tasmania was on 17 March 2012 when he was prescribed Kapanol (morphine).

11. Perhaps obviously, the investigation in relation to Mr Arnold's death concentrated upon the source of the methadone, because an overdose of methadone was why he died. Tasmanian records indicate that he appears to have first been prescribed methadone in April 2012.

12. It is apparent from medical records obtained as part of the investigation that Mr Arnold was a long-term patient of a general practitioner. That practitioner had prescribed methadone (in tablet form) for him for a considerable period – since at least March 2014. Methadone is a potent opioid used, amongst other things, to treat chronic pain, as it was in Mr Arnold's case. Its use is carefully controlled by legislation.

13. As part of the investigation into Mr Arnold's death, records relating to his methadone prescription were obtained from the State Chief Pharmacist. Those records indicate that there were a total of 35 breaches of the *Poisons Act* 1971 (the Act which regulates, *inter alia*, the prescription and supply of methadone) by the general practitioner identified by the Pharmaceutical Services Branch of the Department of Health. The Chief Pharmacist in a report to me said:

> *"…The vast majority (23 of the 35) [breaches of the Act] relate to prescription supplies by [the general practitioner] where prior authorities had expired and the prescriber had not sought further authority… The remaining 11 breaches are more technical in nature and risk assessed by PSB pharmacists as not clinically relevant to patient safety".*

Some Legal Observations

14. When investigating any death, it should be understood that a coroner is required to answer the questions (if possible) that section 28 of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. In answering those questions a coroner makes finding of fact but does not apportion legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. One of the matters that the *Coroners Act* 1995 requires a finding to be made about is how the death occurred.[1] It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

[1] Section 28(1)(b) of the *Coroners Act* 1995

15. I also note that a coroner does not have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. In fact, a coroner may not even say that she or he thinks that someone has committed a crime in relation to the death (or deaths) being investigated.[2]

16. A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment "arises as a consequence of the [coroner's] obligation to make findings … It is not free ranging. It must comment "on any matter connected with the death" … It arises as a consequence of the exercise of the coroner's prime function, that is, to make "findings".[3]

17. Finally, I note that the standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely on someone, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*[4], that is, that the task of deciding whether a serious allegation is proved must be approached with great caution. I have had careful regard to these legal principles in reaching the following conclusions.

Conclusion

18. Mr Arnold died as the result of an overdose of methadone. I cannot determine whether that overdose was deliberate or accidental. The methadone was prescribed for him by a general practitioner who on 35 occasions breached the *Poisons Act* 1971 in relation to the supply to Mr Arnold of methadone.

19. I observe that the issue of methadone prescription has been the subject of comment by coroners in a number of cases in Tasmania. Nonetheless, deaths from methadone toxicity continue to occur. So do breaches of the law by prescribers in relation to the prescription of that potent drug.

20. I consider it necessary to **comment** that the regulatory regime established by the *Poisons Act* 1971 is designed to ensure the safe use of methadone. A failure to adhere to the requirements associated with the prescription of methadone is a serious matter with the potential to have serious and indeed fatal consequences for patients.

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[2] Section 28 (4) of the *Coroners Act* 1995
[3] *Harmsworth v State Coroner* [1989] VR 989 at 996.
[4] (1938) 60 CLR 336

21. I extend my appreciation to investigating officer Constable Steven Fry for his investigation and report.

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

Dated 12 June 2020 at Hobart, Tasmania.

Simon Cooper
Coroner