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 Johnathon Lee Bond

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

a) The identity of the deceased is Johnathon Lee Bond;
b) Mr Bond died as a result of the ingestion by him of drugs, something done by him voluntarily, alone, and with the express intention of ending his own life;
c) The cause of Mr Bond's death was mixed prescription drug toxicity (amisulpride, diazepam and mirtazapine); and
d) Mr Bond died on 26 July 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

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

- Tasmania Police Report of Death for the Coroner;
- An opinion of the Forensic Pathologist;
- The results of toxicological analysis of samples taken at autopsy;
- Ambulance Tasmania records;
- 000 call recordings;
- Letter from Ambulance Tasmania to the Coroner's Office dated 5 June 2020;
- Medical Records – Royal Hobart Hospital;
- Medical Records – Glenorchy Medical Centre;
- Affidavit of Ms Natasha Bond;
- Affidavit of Mr Shaun Hepworth;
- Affidavit of Mr Anthony Hepworth; and
- Affidavits of investigating police officers.

Background

Mr Bond was born on 24 October 1967. He was 51 years of age at the time of his death, married to Mrs Natasha Bond, and in receipt of a Disability Support Pension. Mr and Mrs Bond were married for approximately 30 years. They had three children together.

It is evident that Mr Bond suffered significant mental illness, having been diagnosed as suffering from variously, schizophrenia, depression and early onset dementia. His physical health was also poor.

It is also apparent from the evidence obtained as a result of the investigation in relation to Mr Bond's death that in the lead up to it, his general health, and in particular his mental health, deteriorated.

He variously received treatment at or from the Royal Hobart Hospital (RHH), Statewide Mental Health Services and from his general practitioner. In December 2018, he went to the RHH complaining that he was 'hearing voices'. His medical records indicated that the voices were telling him to self-harm or commit suicide.

On 4 July 2019, Ambulance Tasmania (AT) took Mr Bond to the RHH, having articulated suicidal ideation and again suffering from auditory hallucinations. He was discharged to the care of his general practitioner at the Glenorchy Medical Centre.

Medical records show that, at the time of his death, Mr Bond was prescribed:

- Olanzapine;
- Metformin;
- Amilsulpride;
- Gemfibrozil;
- Peroxicam;
- Mirtazepine; and
- Pantoprazole.

The evidence indicates that Mr Bond was not compliant with his medication regime.

There is clear evidence that Mr and Mrs Bond experienced considerable matrimonial disharmony in the months leading up to his death. That disharmony including conduct on the part of Mr Bond which led, on 28 May 2019, to a police sergeant making a Police Family Violence Order (PFVO) against him.

Circumstances of Death

On 24 July 2019, Mr Bond, whilst shopping with his wife and daughter, made threats to harm them both and himself by crashing their car. Because of those threats, Mr Bond was taken into custody by police and detained for court. The threats were considered to breach the PFVO made on 28 May 2019.

While Mr Bond was in custody, awaiting court, Mrs Bond dropped a shopping bag off at the Hobart Police Station. The bag contained approximately 5 kg of prescribed medication for Mr Bond. The custody sergeant took the bag of medication to the Hobart Reception Prison and consulted with a nurse there. The nurse advised that it would not be appropriate to dispense any of it to Mr Bond without first speaking to his general practitioner. Accordingly, the bag of medication was retained by police in Mr Bond's personal property.

Later, on 25 July 2019, Mr Bond appeared in the Hobart Magistrates Court. A full 'non-contact' Interim Family Violence Order was made.

A condition of that order was that he was not allowed within 50 metres of the family home in Gagebrook.

Mr Bond was duly released from custody. Upon his release, Mr Bond collected his belongings from the Police Station. Those belongings included the shopping bag full of prescription medication.

Because he could not return home, he went to his brother's home at 99 Renfrew Circle, Goodwood. His brother said that when he arrived, Mr Bond had "about 50 boxes of prescription medication in a shopping bag".

Shortly after arriving at 99 Renfrew Circle, and after telling his wife what he either had already done, or intended to do (the evidence is unclear), Mr Bond took an overdose of prescription drugs. Mrs Bond rang her son, Alex. Alex immediately phoned 000 and asked for an ambulance. The time was 5.30pm. Alex told the AT operator that his father suffered from schizophrenia and had taken an overdose of drugs with the intention to commit suicide. He also told the operator where his father was. Mr Bond's emergency was allocated a Priority 2 classification.

At 5.52pm, Mrs Bond called 000. She spoke to an AT operator. Mrs Bond asked if an ambulance would be attending. She told the operator that her husband had taken a deliberate drug overdose, was suicidal and expressed her concerns for his safety. She told the operator the type of drugs her husband had likely taken. No ambulance was dispatched and Mr Bond's classification remained Priority 2.

At 6.06pm, an operator from AT contacted Tasmania Police Radio Despatch Service (RDS) to request police attendance and assistance at 99 Renfrew Circle.

No ambulance had yet been despatched. The job remained at classification Priority 2.

A police RDS operator contacted AT four minutes later, at 6.10pm, to coordinate Tasmania Police and AT attendance at 99 Renfrew Circle. Still, no ambulance was despatched and Mr Bond's Priority 2 classification remained unchanged.

The first police arrived at 99 Renfrew Circle at 6.18pm. The officers found Mr Bond sitting in a chair, with a shopping bag full of prescription medication on the floor near him. He was conscious but drowsy. He told the officers that he had taken approximately 100 tablets in an attempt to kill himself. Concerned (and for good reason), the attending officers contacted Tasmania Police RDS and requested advice as to when they could expect an Ambulance to arrive. They passed on that the need was urgent and that Mr Bond appeared to be drifting in and out of consciousness. Still, no ambulance was despatched. He again remained at Priority 2.

Finally, at 6.20pm, AT allocated a crew to the job. That crew was not mobile, however, for another 8 minutes, and then only after another call from attending police. When the crew went mobile at 6.28pm, Mr Bond's classification was upgraded to Priority 1.

The ambulance arrived at 6.34pm, 1 hour and 4 minutes after the first 000 call.

It was apparent to the attending paramedics (as it had been to the attending police for some time) that Mr Bond was dangerously unwell. At 6.42pm, Police passed on a message at the request of the paramedics that an intensive care specialist paramedic was required. The intensive care paramedic was immediately despatched and arrived at 99 Renfrew Circle at 6.53pm.

Attempts were made to stabilise and treat Mr Bond at the scene. He was rushed to the RHH, the ambulance leaving Goodwood at 7.07pm and arriving at the RHH 10 minutes later. Whilst Mr Bond was in the ambulance en route to the RHH his level of consciousness continued to decrease.

Mr Bond was admitted to the RHH. Despite treatment in the hospital's Intensive Care Unit, he could not be saved, and died at 2.30am the following day, 26 July 2019.

Investigation

The fact of Mr Bond's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and transferred to the Hospital's mortuary. At the mortuary, experienced Forensic Pathologist, Dr Donald Ritchey, performed an autopsy. He found granular debris in Mr Bond's stomach. Dr Ritchey said the debris was consistent with dissolved pills and / or tablet fragments.

Samples were taken at autopsy and subsequently analysed at the laboratory of Forensic Science Service Tasmania. Having regard to his findings at autopsy, and the results of the toxicological analysis of samples, Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Bond's death was mixed prescription drug toxicity.

In particular, amilsulpride, an antiemetic and antipsychotic medication prescribed for Mr Bond to treat the symptoms of his schizophrenia, was found to have been present in the samples. That drug was within the reported fatal range. Diazepam and the anti-depressant, mirtazapine, were also found to be present in the samples analysed.

There is no evidence of the involvement of any other person in Mr Bond's death. I am satisfied on the evidence that at the time he ingested the prescription medication which caused his death, he did so voluntarily, alone and with the express intention of ending his own life.

There is no evidence to suggest that Mr Bond's death was in any way suspicious.

Discussion

It is, in my view, clear that there was some delay on the part of AT in responding to Mr Bond. It is not apparent why this was so. AT advised that at or about the time of the emergency in relation to Mr Bond, there were "5 ambulance crews ramped at the Royal Hobart Hospital and 7 incidents waiting to be dispatched". Be that as it may, and whilst the allocation of the incident as a priority 2 response at 5.30pm might well have been appropriate, it was probably no longer appropriate when Mrs Bond made the second 000 call at 5.52pm. It was certainly no longer appropriate when attending police provided extra information and sought urgent advice as to the ETA of an ambulance.

It is not at all apparent to me why an ambulance was not despatched before 6.28pm, particularly in light of the calls from attending police.

It is also not clear to me why it was that the tasking in relation to Mr Bond's case was not upgraded to Priority 1 until 6.28pm.

Conclusion

I extend my appreciation to investigating officer, Constable Monique Featherstone, for her investigation and report.

The circumstances of Mr Bond's 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 Bond.

Dated 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner