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 Melissa Mary Spencer

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

a) The identity of the deceased is Melissa Mary Spencer;
b) Ms Spencer died as a result of an accidental overdose of prescription drugs;
c) The cause of Ms Spencer's death was mixed drug toxicity; and
d) Ms Spencer died between 23 and 24 June 2019 at 76 Windsor Street, Glenorchy, Tasmania.

Introduction

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

- Tasmania Police Report of Death for the Coroner;
- An opinion of the Forensic Pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Affidavit of Ms Agnes (Beverly) Spencer, Ms Spencer's mother;
- Affidavit of Ms Denise Stones;
- Affidavits of investigating police;
- Medical Records – Royal Hobart Hospital;
- Medical Records – O'Briens Bridge Medical Centre;
- Report – Department of Health – Pharmaceutical Services Branch; and
- Forensic and photographic evidence.

Background

2. Ms Spencer was born on 3 April 1965 in Hobart. Her parents were Lance and Agnes Spencer. At the time of her death she lived alone at 76 Windsor Street, Glenorchy. She had no children and never married. A nurse by occupation, she suffered a significant back injury on 5 November 1990 aged 26. Thereafter she lived with the consequences of that injury and with significant ongoing chronic pain.

3. Ms Spencer was an active volunteer with St John Ambulance.

4. She was treated by general practitioner, Dr Anthony St J Hodge. She saw Dr Hodge on average once per month, essentially for prescription renewal.

5. She was a heavy smoker.

6. Ms Spencer had a history of falls. Approximately one year before her death she suffered a fall and fractured ribs and injured her shoulder. Reportedly, the fall occurred while she was sleep walking.

7. Approximately six to eight weeks before her death, Ms Spencer suffered significant bruising to one of her arms. Again, the bruising was the result of the fall which, again, reportedly occurred whilst she was sleep walking.

8. Two or three weeks prior to her death, Ms Spencer reportedly sustained another fall. She sustained two minor cuts to her head as a result.

9. Ms Spencer's medical records indicate that she was using (or at least prescribed) the following medications at about the time of her death:

    - Kapanol;
    - Mersyndol;
    - Temazepam;
    - Nexium;
    - Prozac; and
    - Sotacor.

10. Kapanol is morphine, a central nervous system (CNS) depressant. Mersyndol contains codeine, also a CNS depressant. It is designed to be used for short term pain relief. Temazepam is a benzodiazepine, often used to assist with sleep and also designed for short term use. Prozac (or fluoxetine) is a selective serotonin reuptake inhibitor antidepressant. Nexium is used to treat gastric disorders. Sotacor is used to treat abnormal heart rhythms.

11. Investigations after her death indicate that Ms Spencer was also taking other medications. I will return to that issue later in this finding.

Circumstances of Death

12. On Monday 24 June 2019, Ms Spencer's mother contacted a friend, Ms Denise Stones. Mrs Spencer told Ms Stones she was concerned about her daughter as she had been unable to get in touch with her.

13. As a result of the phone call, Ms Stones (who had a key to Ms Spencer's residence) went to her home. She entered through the front door and found Ms Spencer laying on her side on the couch in the lounge room. She was unresponsive and cold to the touch. Ms Stones phoned 000 and commenced CPR. An ambulance arrived shortly after. Despite efforts of the paramedics, Ms Spencer was unable to be revived.

14. Ambulance paramedics contacted police who were on the scene at about 6.20pm. An investigation was commenced. No signs of violence or a forced entry of the residence were identified. The lights in some of the rooms were on and so was the television (which had gone into standby mode).

15. Officers from both the Criminal Investigation Branch and Forensic Services attended the residence and carried out enquiries. Ms Spencer's body was photographed. The scene was photographed and forensically examined. Numerous drugs were found at the scene and seized, along with Ms Spencer's mobile phone and a number of medication prescriptions.

16. Nothing suspicious was identified at the scene. No evidence to suggest the involvement of any other person in Ms Spencer's death was found.

17. Ms Spencer's body was formally identified and then transported to the Royal Hobart Hospital.

Investigation

18. At the Royal Hobart Hospital, an autopsy was performed by experienced Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey found that there was evidence of acute aspiration of gastric content by Ms Spencer. In addition, she was morbidly obese with a body mass index of 40. Moderate atherosclerotic vascular disease was also identified. However, Dr Ritchey could not find a clear anatomical cause of death.

19. Samples were taken at autopsy and subsequently analysed at the laboratory of Forensic Science Service Tasmania. A significant array of drugs were identified as having been present in those samples. The drugs included morphine, codeine, doxylamine, paracetamol, nitrazepam, pregabalin, varenicline and erythromycin.

20. Four of those drugs – morphine, codeine, doxylamine and nitrazepam – are CNS depressants. The analysis found that both morphine and doxylamine were present in elevated concentrations.

21. The evidence from Forensic Science Service Tasmania was that CNS depression may result in symptoms including feeling sleepy and uncoordinated, staggering, blurred vision, impaired thinking, slurred speech, impaired perception of time and space, slow reflexes and breathing, decreased heart rate, reduced sensitivity to pain and loss of consciousness possibly leading to coma or death.

22. While morphine was detected at an elevated level of 0.88 mg/L, a degree of caution needs to be had when endeavouring to identify the forensic significance of this elevated level. This is because tolerance to central nervous system depressants in general, and morphine in particular, develops over time, particularly in relation to long-term users of the drug.

23. Increased tolerance means that larger and/or more frequent doses may be required to produce the same pharmacological effects. The result of all this is that therapeutic blood levels in tolerant individuals can greatly exceed reported therapeutic ranges.

24. As part of the investigation, a report was also sought and obtained from the Tasmanian Department of Health's Pharmaceutical Services Branch (PSB). The PSB has statutory responsibility for administering the *Poisons Act* 1971 and the *Poisons Regulations* 2018. That Act and those regulations regulate the administration of all narcotic (or schedule 8) substances in the State. Morphine is a schedule 8 substance.

25. The PSB keeps a record of all prescribing on its database. The records show who received, who prescribed and where and when substances were dispensed. In addition to prescribing records, records of all the authorities issued by the PSB under the *Poisons Act* to medical practitioners authorising the prescription of narcotic substances are kept.

26. The legal position is that if a patient has previously been declared drug dependent by a medical practitioner, an authorisation to continue to prescribe is required immediately. Relevantly, Ms Spencer was first declared by a medical practitioner in Tasmania to be drug dependent in February 1996. Accordingly, after that time, authorities to dispense schedule 8 substances (including morphine) were required for her.

27. The PSB records indicate that since 2009 there were 112 breaches of the *Poisons Act* 1971 in relation to the supply of relevant substances to Ms Spencer.

28. The PSB in its report indicated that a risk benefit assessment conducted by it found that 37 of the 112 breaches were "technical in nature" and did not "meaningfully impact on patient safety at the time of supply". I accept that this was so.

29. However, the PSB, in the same report, indicated that 14 breaches related to prescribers not holding authorities to prescribe narcotics and 20 breaches related to excessive and early supply of schedule 8 substances to Ms Spencer. The remaining 41 breaches related to the supply of codeine to Ms Spencer.

Discussion

30. The evidence satisfies me to the requisite legal standard that the cause of Ms Spencer's death was mixed drug toxicity. It is evident from the exhibits found at the scene and the results of toxicological analysis of samples taken at autopsy, that Ms Spencer was prescribed a large number of drugs. Several of those drugs were central nervous system depressants. A number of those drugs were prescribed for many years but designed only for short term use.

31. It is also quite apparent, from the evidence, that in this case, there has been a significant departure from the standards required by the legislation which governs the prescription of schedule 8 drugs. Particularly concerning are the 20 breaches relating to excessive and early supply of morphine to Ms Spencer.

32. Even the so-called 'technical' breaches are a matter of concern. The regulatory system in place is designed to provide a regime which enables the safest possible therapeutic use of narcotic substances by members of the community, recognising that those narcotic substances can have death as a side-effect.

33. The breaches with respect to the supply of codeine also are a matter of concern, particularly given that it was being provided at a time when morphine was also being prescribed.

34. I am satisfied that virtually all of the breaches relate to the prescribing practices of Ms Spencer's regular GP, Dr Hodge. I note these findings were sent in draft to Dr Hodge. He was invited to make any comment or submission about them. No reply was received from him. I assume therefore, Dr Hodge does not take issue with anything in these findings.

35. There is no evidence that would allow me to conclude that any other person was involved directly in Ms Spencer's death. There is no evidence that the overdose of drugs which caused her death was taken by her with the express intention of ending her own life.

Comments and Recommendations

36. The circumstances of Ms Spencer's death highlight the dangers associated with long-term use of narcotic and other central nervous system depressant drugs. I **comment** that the system established by the *Poisons Act* 1971 to regulate the prescribing, dispensing and use of narcotic and similar drugs is important to ensure their safe use.

37. I convey my sincere condolences to the family and loved ones of Ms Spencer.

Dated: 9 November 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner