MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Timothy John Wellington

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

a) The identity of the deceased is Timothy John Wellington;
b) Mr Wellington died in the circumstances described in this finding;
c) The cause of death was the intravenous injection of foreign debris (associated with drug use); and
d) Mr Wellington died between 15 and 16 January 2017 at Lindisfarne, Tasmania.

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

- The Police Report of Death for the Coroner;
- Life extinct and identification affidavits;
- Affidavit of the Forensic Pathologist who conducted the autopsy;
- Toxicology report;
- Affidavit of Enid Wellington, Mr Wellington's mother;
- Affidavit of Robert Owens, next door neighbour of Mr Wellington;
- Affidavits of nine police officers, including CIB officers, attending the scene and investigating the circumstances surrounding Mr Wellington's death;
- Affidavit of a Forensic Services officer, who examined and photographed the scene;
- Police records for Mr Wellington;
- Medical records of Dr Robert White, Mr Wellington's general practitioner;
- Royal Hobart Hospital medical records;
- Pharmaceutical Services Branch records relating to Mr Wellington;
- Report of the Acting Chief Pharmacist regarding the supply of Schedule 8 substances to Mr Wellington; and
- Report of Dr Nicolle Ait Khelifa, consultant psychiatrist and addiction medicine specialist.

Background

Timothy John Wellington, son of Robert James Wellington (deceased) and Enid Frances Wellington, was born on 11 March 1972 and was aged 44 years at the time of his death. He was the father of a son, Daniel Korotki, born in 1996. Mr Wellington and Terena Korotki (Daniel's mother) separated, which resulted in estrangement between Mr Wellington and his son.

Mr Wellington completed schooling to grade 12 level. After leaving school, he gained employment for a short time but did not continue with any employment after this short period.

Nearing the end of his teen years, Mr Wellington became addicted to cannabis and alcohol. He had a severe case of kidney stones at 19 years of age and, as a result, was prescribed pethidine (a painkiller). He became dependent on pethidine and started to also seek and use other illicit drugs. At the age of about 20 years, Mr Wellington told his mother that he had been abused sexually by one of his school teachers. He sought some psychiatric treatment but he did not continue with it.

Due to Mr Wellington's use of drugs, his mother was no longer able to have him live with her. Therefore, whilst still in his twenties, Mr Wellington started living at Bethlehem House, where it is reported that he began to intravenously inject illicit drugs. In 1999, Mr Wellington was admitted to the methadone program under the supervision of his general practitioner, Dr Robert White. Eventually, Mr Wellington recommenced living with his mother in Lindisfarne, and remained living with her for the 12 years before his death.

Mr Wellington had few personal relationships and led quite a reclusive lifestyle. He did not have any known friends at the time of his death and was only known to associate with people when purchasing drugs. Toward the end of his life, he would only visit the pharmacy (for his medication) and the beach. He collected items that he found at the beach and "hoarded" them at home. Mr Wellington was a heavy smoker and also suffered from a gambling addiction. He smoked between 20 and 30 cigarettes a day and often tried to cease the habit with no success.

In late 2015 Mr Wellington commenced using methamphetamine (ice). His mother said that his use of ice changed his behaviour for the worse.

Mr Wellington suffered suicidal ideation and presented to hospital on many occasions stating that he wanted to harm himself and others. On 2 May 2015, for example, Mr Wellington was taken to the hospital by police officers after having locked himself in his bathroom with petrol, threatening to set fire to himself. Subsequently, in 2016, Mr Wellington presented to the Royal

Hobart Hospital on six occasions due to thoughts of self-harm and harm to others, the last such presentation being on 2 September 2016. On each occasion he was released into his own care with follow up from Dr White.

Over the last 12 months before his death, Mr Wellington's behaviour became more unpredictable, erratic and aggressive. He had, at times, become violent enough that Mrs Wellington had to call the police as she feared for her safety and that of her son.

Mr Wellington was placed on the methadone program in about 1999 and, from 2002, Dr White supervised his daily methadone dosing. Mr Wellington was in the process of reducing his intake of methadone at the time of his death. Whilst on the methadone program Mr Wellington continued to use other illicit drugs with regular urine drug screens undertaken being positive, at times, for cannabis, benzodiazepine, amphetamines and opiates.

Mr Wellington's local pharmacy was Chem-mart in Lindisfarne and this is where he was dispensed his methadone and other medications. As the pharmacy was closed on Sundays, Mr Wellington would collect a takeaway dose on Saturday for him to consume on the Sunday. On long weekends, Mr Wellington would collect two takeaway doses. He had a long history of injecting his takeaway doses of methadone rather than taking it orally as prescribed. Dr White monitored this along with staff at Chem-mart.

Mr Wellington had medical conditions other than being drug dependent. Records show that he had last seen his doctor three days prior to his death on 13 January 2017. Dr White treated Mr Wellington for Cluster B personality disorder (including delusions), anxiety, depression, chronic obstructive pulmonary disease, asthma, gastro-oesophageal reflux, recurring kidney stones and chronic pain. His regular prescribed medication was methadone, diazepam, pregabalin and quetiapine.

Circumstances Surrounding the Death

At around 9.00am on 14 January 2017, Mr Wellington attended the Lindisfarne Village Chem-mart where he received his daily dose of methadone. This dose was consumed orally in store and he obtained a takeaway dose for him to consume the following day, as authorised by Dr White.

At around 9.15am on 15 January 2017, Mr Wellington was outside at the back of his house having a cigarette. Mrs Wellington called out to him, saying goodbye and that she was going to church, and left.

At about midday Mr Wellington's neighbour, Robert Owens, saw Mr Wellington outside on the back door step. Mr Owens said hello but Mr Wellington did not respond to him. Mr Owens said that Mr Wellington just sat there with his elbows resting on his knees and his face in his hands, appearing "very down".

Around lunch time on 16 January, Mrs Wellington went to see Mr Wellington in his room. Mrs Wellington opened his door and saw that Mr Wellington was seated with his head slumped forward and apparently listening to music through head phones. Mrs Wellington thought that he had blacked out as he had done so on previous occasions. She then left the room. Approximately 30 minutes later, she re-entered his room and saw him in the same seated position. She felt his hand and he was cold to the touch and unresponsive. Mrs Wellington then called for an ambulance. Ambulance paramedics who arrived shortly afterwards confirmed that Mr Wellington was deceased.

Investigation

Police officers, including CIB, drug squad and forensics officers, attended the scene of Mr Wellington's death. They formed the view that there were no suspicious circumstances surrounding his death. There was no evidence or any note to suggest that Mr Wellington's death was a result of suicide. They noted that his bedroom was extremely cluttered, consistent with his compulsive hoarding. They located a large number of butterfly needles in a tin inside the doorway and empty packets of alcohol wipes on top of the bed. No other drug related items could be located, however the room was difficult to search due to the extent of the clutter.

A toxicological examination of Mr Wellington's post-mortem blood sample revealed that multiple prescription medications were identified, (being methadone, quetiapine, diazepam and mirtazapine) as well as THC (cannabis). These were not present in what is described as the "toxic" or "fatal" ranges.

Dr Donald Ritchey, Forensic Pathologist, performed an autopsy upon Mr Wellington and determined that the cause of death was a result of intravenous injection of foreign debris complicating chronic intravenous drug use. In his report, Dr Ritchey stated that:

"These findings are interpreted by me to suggest that Mr Wellington has crushed tablets intended for oral ingestion and injected the material intravenously. Insoluble foreign material (probably microcrystalline cellulose) within the tablets (used in tablet manufacturer as a binder) has become trapped within the small vessels of the lungs resulting in acute pulmonary hypertension and death."

Dr Ritchey indicated that significant contributing factors were depression with anxiety, chronic hepatitis with portal fibrosis and emphysema. Dr Ritchey was of the view that injection of liquid methadone (intended for oral consumption) may have played a part in Mr Wellington's death but that substance was unlikely to have caused the pathology seen by Dr Ritchey histologically, which was the result of injection of crushed tablets.

The evidence indicates that at some time between 1.00pm on 15 January and the morning of 16 January, Mr Wellington went into his bedroom, sat down and crushed some tablets, likely those prescribed to him. He then injected the crushed tablets into his arm. It is also very likely that he injected his takeaway dose of methadone prescribed by Dr White. In this regard, Mrs Wellington told police officers attending the address that Mr Wellington would usually inject his weekly takeaway dose on Sunday and, as a consequence, he would remain in his room and she would not see him until Monday. Sometime after injecting the crushed tablets and methadone, Mr Wellington died and remained in his seated position near his bed.

I find that Mr Wellington did not intend to end his life and that death due to injecting crushed pills was accidental.

Comments

The central issue explored in this investigation was whether Mr Wellington's death could have been prevented by restricting his access to takeaway doses of methadone, which he was known by Dr White to inject intravenously as a matter of course. I have received a comprehensive report from the Chief Pharmacist analysing relevant records of the Pharmaceutical Services Branch (PSB), the body responsible for authorising Dr White to prescribe methadone to Mr Wellington pursuant to the Tasmanian Opioid Pharmacotherapy Program (TOPP). In the report the Chief Pharmacist expressed concerns that Dr White contravened the guidelines for the TOPP by prescribing takeaway doses of methadone to Mr Wellington despite his clear history of injecting drugs. The Chief Pharmacist also held concerns regarding the prescribing to Mr Wellington of concurrent multiple sedating and psychotropic medications, concurrent and extended prescribing of benzodiazepines, and concurrent prescribing of other sedative and psychotropic medications.

I sought an independent expert opinion from Dr Nicolle Ait Khelifa, consultant psychiatrist and addiction medicine specialist, regarding any issues associated with Dr White's prescribing to Mr Wellington. In her report, Dr Ait Khelifa made the following comment:

"Ideally with a history of injecting take away doses of methadone he should not have been in receipt of takeaway doses of methadone. However there is difficulty accessing seven day dosing in Tasmania.

Transport options are limited and there may be an increased associated cost of travel to go to an alternative pharmacy out of area. This needs to be taken into account in the rationale for continuing the Sunday takeaway dose as exceptional, until the switch to the safer preparation of Suboxone could occur."

Further, Dr Ait Khelifa made the comment that, although general practitioners providing opioid replacement therapy were advised of the TOPP guidelines, they were given, in her opinion, limited practical support to implement the changes in the policy due to capacity issues. She indicated that support is required regarding provision of takeaway doses, the role of Suboxone and the prescribing of benzodiazepines.

Dr Ait Khelifa further stated in her report:

"It was reported Mr Wellington had multiple co morbidities, opioid use disorder, stimulant use disorder-amphetamine type substance, hypnotic or anxiolytic use disorder (benzodiazepine), cannabis use disorder, schizophrenia - paranoid type, anxiety disorder, tobacco use disorder and chronic pain disorder. There appeared a progressive deterioration of Mr Wellington's mental state from the repeated exposure to methamphetamines and cannabis to more of a psychotic picture. From Dr White's clinical notes with some endorsement by specialists it is understandable why he prescribed Mr Wellington with multiple psychotropic medications: quetiapine, mirtazapine, sodium valproate and diazepam despite the risks of accidental injury or overdose, in an attempt to treat his symptoms, minimise his distress and risk to self and others. When Mr Wellington had been seen in Royal Hobart Hospital emergency department by psychiatric register Dr Jeremy Smith 12/7/2016 the recommendation had been to consider increasing the quetiapine if increasing delusions and ongoing amphetamine use. There was a plan to reduce off the diazepam by Dr White once advice sought on the management of the benzodiazepine reduction from his treating psychiatrist Dr Ian Wilson. Mr Wellington had also been under the care of the pain clinic to try to address his chronic non-malignant pain.

It is noted that the psychotropic medication was dispensed on a daily basis, an appropriate safety measure.

Dr White had made repeated efforts to engage Mr Wellington with Adult Community Mental Health Services (CMHT), psychology, private psychiatrist, and non-government organisations providing mental health care such as the Anglicare Personal Helpers and Mentors Program. He had also been seen by a clinician at the alcohol and drug service directed by police due to cannabis possession. Mr Wellington had become reluctant to reconsider referral back to CMHT due to his experience of his last consult with the psychiatrist at the service and his prior engagement appeared contemplative. There are no specialised services for dual diagnosis in Tasmania, a gap in service provision. Specialist dual diagnosis

teams aim to support the responses of mental health services and drug treatment services to individuals with both mental health illness and substance use problem. Dr White had provided a consistent therapeutic relationship in the absence of integrated care being available."

It is apparent from the records and reports of Dr White, in evidence in this investigation, that he made significant efforts to treat Mr Wellington over many years and to refer him to appropriate services. He recognised the risk inherent in prescribing takeaway doses of methadone in light of his long-term drug abuse. He stated that his plan was to transfer Mr Wellington to Suboxone, a safer opioid replacement, in February 2017.

I fully accept that it would have been a difficult task for Dr White to treat and prescribe for Mr Wellington, as outlined by Dr Ait Khelifa, especially if the specialist resources for such a patient were not optimal. Nevertheless, the records show that, over many years, Mr Wellington told Dr White that he was abusing methamphetamine and Dr White continued to allow takeaway doses of methadone, which he knew Mr Wellington would inject. Consuming both drugs intravenously is inherently dangerous. On many occasions over the years, Dr White prescribed three takeaway doses per week. Dr White should not have prescribed takeaway doses and should have required the methadone to be consumed orally at the pharmacy. He should also have notified PSB of the fact that Mr Wellington was in the habit of injecting his takeaway doses.

Whilst the damage caused by long-term intravenous injection of methadone may well have contributed to Mr Wellington's death, it was not the acute cause. I am mindful that the acute cause of death was his actions of crushing his other prescribed tablets and injecting them intravenously. Accepting the opinions of Dr Ait Khelifa on this issue, I do not criticise Dr White's prescribing of these medications.

I extend my appreciation to investigating officer Constable Sam Brady for her investigation and report.

The circumstances of Mr Wellington'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 Wellington.

Dated: 13 August 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner