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 Karen Tracey Reaks

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

a) The identity of the deceased is Karen Tracey Reaks.

b) Ms Reaks was born in Victoria on 9 August 1971. At the time of her death, she was aged 49 years and was living alone at Queenstown, Tasmania. Ms Reaks never married and did not have children. She was not employed but before her death had been engaging in university study and volunteering within her local community. Ms Reaks was diagnosed with borderline personality disorder and suffered from an anxiety disorder. She had a history of suffering suicidal thoughts but there was no evidence that she was contemplating suicide in the weeks before her death. She also suffered systemic lupus erythematosus (SLE), an autoimmune condition causing widespread inflammation and tissue damage. Ms Reaks was under the regular care of her treating health professionals, including her general practitioner, rheumatologist, psychiatrist and psychologist. She was prescribed a range of medications to assist her, including amitriptyline, zopiclone and periciazine. A carer from Family Based Care - Bronwyn Edwards - visited her five times per week to provide her with support and assistance. In the weeks before her death, Ms Edwards noticed that Ms Reaks was suffering falls and regular episodes of dizziness and memory loss.

On the morning of Friday 12 March 2021 Ms Edwards visited Ms Reaks. At that time, Ms Reaks refused to attend a doctor's appointment later that day for tests to investigate her recent, concerning health symptoms. Ms Reaks was not seen alive after the visit by Ms Edwards, although she spoke to her father the following day. The last text message sent from her phone was at 6.11pm on Saturday 13 March. When Ms Edwards arrived for her visit on the morning of Monday 15 March, she found Ms Reaks deceased, lying face down on the kitchen floor, partially dressed with the fridge door open. Ambulance officers

arrived and noted that she had been deceased for some time. When police officers attended the scene, they did not identify any suspicious circumstances.

c) Ms Reaks died as a result of combined prescription drug intoxication. Toxicological testing revealed high levels of her prescription medication (zopiclone, amitriptyline and periciazine) that would have had the combined effect of significantly depressing the central nervous system. Her medical condition, SLE, also contributed to her death.

d) Ms Reaks died between 13 and 15 March 2021 at Queenstown, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Ms Reaks' death. The evidence includes:

- The Police Report of Death for the Coroner;
- An opinion of the forensic pathologist who conducted the autopsy;
- Toxicology report regarding analysis of post-mortem blood sample;
- Affidavits confirming life extinct and identification;
- Affidavit of Jeffrey Reaks, father of Ms Reaks;
- Affidavit of Bronwyn Edwards, carer of Ms Reaks; and
- Records from the Queenstown General Practice, including specialist reports.

Comments and Recommendations

I find that Ms Reaks ingested her prescription medication in quantities greater than prescribed. It is quite possible that she did so with the intention of ending her life. About five months before her death, she had told her psychiatrist that she would consider "storing her pills" for the purpose of a deliberate overdose. However, there was no evidence after that time that she intended to take such action and I cannot make a positive finding of suicide.

Alternatively, it is possible that she took excess medication to relieve psychological symptoms but without suicidal intention. The scene of death tends to suggest that she had not planned her death. I note that Ms Reaks had been advised by her doctor before her death to cease taking amitriptyline, one of the substances found in her blood after her death.

In a helpful report received from her general practitioner, Dr Dennis Pashen of Queenstown General Practice, he stated that Ms Reaks' prescriptions were monitored carefully by her treating health professionals but those health professionals had no ability to monitor compliance with prescriptions. He noted that, in the normal course of events, medications such as those taken by Ms Reaks, would not be monitored using blood levels but by time intervals between prescriptions. I fully accept his evidence that the time intervals for prescribing medications to Ms Reaks were appropriate if she had been using them as prescribed. It is difficult upon the evidence to determine the extent to which Ms Reaks had adhered to her correct prescribing regime.

Dr Pashen commented that a doctor's inability to monitor a patient's compliance with medications is a safety issue and represents a "missing link" in the health system. I note his comments, although it is not appropriate to discuss such issue further in this finding.

The circumstances of Ms Reaks' 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 Karen Tracey Reaks.

Dated: 8 October 2021 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner