MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Sandra Anne Brown

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

a) The identity of the deceased is Sandra Anne Brown (Ms Brown);

b) Ms Brown died in circumstances set out below;

c) Ms Brown's cause of death was hypothermia, likely related to drug toxicity; and

d) Ms Brown died on 20 August 2019 at the Launceston General Hospital (LGH), Launceston, Tasmania.

Introduction

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity and life extinct;
- An opinion of the pathologist who conducted the autopsy;
- Report of a forensic scientist from Forensic Science Service Tasmania which sets out the results of the toxicological analysis of samples taken at autopsy;
- Medical records obtained from Ms Brown's general practitioner;
- Records obtained from Ambulance Tasmania (AT);
- Medical records obtained from the LGH;
- Dispensing records obtained from Kings Meadows Discount Pharmacy and Epic Pharmacy Kings Meadows;

- Affidavit of Mr Anthony Mace;
- Affidavit of Constable Matthew Lockhart; and
- Affidavit of Sergeant Genevieve Hickman.

Background

Sandra Anne Brown was born in Tasmania on 8 June 1965. She was also known as Sandra Anne Stanshall, Sandra Anne Cleary and Sandra Anne Brennan throughout her life. At the time of her death she was 54 years of age and she was living alone at Kings Meadows, Tasmania.

Ms Brown had never married but had a number of de facto relationships during her life. She had five children namely Simone Cleary, Josh Cleary, Brodie Brennan, Jessie Glover and Abby Hefford to a number of partners. The relationships which produced her children ended many years before her death and her children had also moved out of the family home many years before that point in time. At the time of her death Ms Brown was socially isolated and had no visits from her family and few visits from her friends.

Ms Brown suffered from a range of medical issues throughout her life including asthma, bi-polar disorder, epilepsy, chronic obstructive pulmonary disease (COPD), type II diabetes, osteoarthritis, gall stones, an iron deficiency and she was on a waiting list for an endoscopy and a colonoscopy. Ms Brown was subsequently taken off the waiting list in February 2019 because she missed 2 appointments. She also suffered from some mental health difficulties including depression for which she had previously received treatment. In her general practitioner's notes for 5 October 2017, it is recorded Ms Brown was suffering from COPD and that she was a heavy smoker. The doctor's impression was Ms Brown was *"destined for premature death from COPD, diabetes, smoking cocktail."*

In 2019, her mobility decreased, and she was receiving home care assistance from Anglicare and she had a case manager appointed to advocate for her. The assistance provided by Anglicare consisted of showering and domestic support, although in June 2019 Ms Brown was still getting her own groceries of a weekend. Her general practitioner noted on 7 June 2019, Ms Brown was not coping with attending to her own hygiene and it was thought she required daily support. There is an application mentioned in the notes for National Disability Insurance Scheme (NDIS) funding and a referral was made to Launceston Community Nursing, however, the notes reveal that organisation does not look after patients who require personal hygiene care. By 10 July 2019, the general practitioner's notes indicate trouble is being experienced accessing the NDIS and that an application needs to be fast

tracked. A referral was then made to the Adult Community Mental Health Service, however, that service indicated they were not able to see Ms Brown because she had no evidence of acute psychosis. Accordingly, a referral was sent to the psychiatrist Dr Ratcliffe who had previously seen her. That referral was sent on 6 August 2019.

At 2.19 AM on 17 August 2019, Ms Brown presented to the emergency department at the LGH having been taken there by ambulance. She was suffering from breathing problems and was diagnosed with COPD. She was examined and a chest x-ray was performed and a blood sample was taken and sent to pathology. She suddenly decided she wanted to go home as she had something urgent to do. She said she would return. She was advised that was not a good idea and although she was quite breathless and cyanosed she was adamant that she was leaving. Ms Brown signed paperwork which acknowledged she was discharging herself against medical advice.

Circumstances of Death

On the afternoon of Monday 19 August 2019, an unidentified male neighbour of Ms Brown's became concerned for her welfare and contacted Anglicare. A female staff worker attended Ms Brown's home locating her in her bedroom. Ms Brown was found on the floor between her bedside table and her bed face down. She was responsive to touch but appeared to be in a deep sleep. No bleeding was observed. A Webster pack was present. An ambulance was called at 2:56 PM with ambulance personnel being at Ms Brown's side by 3:09 PM. Her initial Glasgow Coma Score was 4 and her temperature was measured at 27.5 degrees Celsius. She was experiencing difficulty breathing. Ms Brown was transported by AT to the LGH arriving at 3:48 PM. She was assessed as being severely hypothermic and she had severe respiratory and metabolic derangement. She was treated and transferred to ICU for ongoing resuscitation. Ms Brown was unresponsive and did not regain consciousness.

There was evidence which suggested Ms Brown was found by a friend named Stephanie Fleming. Sergeant Hickman from the Coronial Division of the Magistrates Court spoke to Ms Fleming who advised she did not find Ms Brown at home and she was only present at the hospital after Ms Brown had been transported from her home by ambulance personnel. Ms Fleming advised Sergeant Hickman Ms Brown had been found by 2 males; one a neighbour who had since died while the other one she knew by the name "Snowy' who lived at Hadspen.

I listened to the 000 recording obtained from AT and identified 2 people present at Ms Brown's home when that call was made. One of those people is the female staff member from Anglicare whereas the other person is identified in that recording as Anthony. Subsequent enquiries determined Anthony is Anthony Mace of Hadspen. Mr Mace has

provided a statement in which he confirms he is known by the nickname "Snowy" which is the person identified by Ms Fleming. Mr Mace says he has known Ms Brown since she was about 17 years of age, that he had been in a relationship with her many years ago, and that he has visited her at her home regularly for many years. He says she was reasonably healthy when he first met her but her health deteriorated over the years. He says she was on a number of medications but he is not sure what conditions the medications were prescribed for. He confirms he found Ms Brown on the ground next to her bed on 19 August 2019. It looked to him like she had rolled out of bed. He spoke to Ms Brown's carer and they covered her with a blanket to keep her warm and called the ambulance. He says the ambulance arrived and removed her from the premises. He locked her home after the ambulance left and he subsequently received a message that she had passed away in hospital.

The Investigation

Formal identification was completed by staff at the LGH. Dr Dalby declared life to be extinct.

A post-mortem was conducted by forensic pathologist Dr Terence Brain on 22 August 2019. In his report to the Coroner, Dr Brain says Ms Brown's cause of death was hypothermia, likely related to drug toxicity. He also noted Ms Brown had cardiomegaly, diabetes, she was obese, she had COPD, bronchitis and early bronchopneumonia and she had a history of a bipolar disorder. I accept Dr Brain's opinion as to Ms Brown's cause of death.

Toxicological testing was conducted on a post mortem blood sample as that was deemed by the forensic scientist, Mr Neil McLachlan-Troup, to be the optimal sample of the samples which were provided on which to conduct toxicological testing. His report reveals a large number of medications in Ms Brown's blood some of which were consistent with those given to her while she was being treated in hospital namely morphine, midazolam, metoclopramide, lignocaine and furosemide. Those drugs were detected at either therapeutic or sub therapeutic levels. No alcohol was detected. Caffeine and nicotine were detected. Two other prescribed medications were detected, however, 2 others namely fluvoxamine and amisulpride were detected at within the fatal range and toxic range respectively. Acetone was also detected.

Acetone is normally found in blood and urine as it is naturally produced and disposed of in the body through normal metabolic processes. However, acetone concentrations normally identified in blood and urine are generally well below the level found in this case. Acetone levels are often markedly elevated during fasting or metabolic acidosis (diabetic ketoacidosis or alcoholic acidosis). Metabolic acidosis can result in coma or death if it remains untreated.

Fluvoxamine is an anti-depressant agent which inhibits the re-uptake of the neurotransmitter, serotonin, from the junction between nerves in the brain. It is indicated in the treatment and relapse of major depression and obsessive-compulsive disorders. Amisulpride is an antipsychotic agent indicated in the treatment of acute and chronic schizophrenia.

The symptoms of overdose of some of these drugs or a combination of them include, amongst others, drowsiness and sedation, coma, hypotension and extrapyramidal symptoms, somnolence and dizziness, cardiac events (tachycardia, bradycardia, hypotension), liver function disturbances, convulsions, coma and death.

Investigations found Ms Brown had been prescribed and taken fluvoxamine and amisulpride for a long period of time[1] to assist with the management of her mental health symptoms. The pharmacy that dispensed her medications did so in a pack[2] to assist her.

I have analysed the prescription records carefully. The amount of fluvoxamine and amisulpride prescribed in 2019 was not excessive. In both cases, as at 20 August 2019, Ms Brown would have had a supply in hand over and above the amount of each medication that was required if she had taken that medication pursuant to the general practitioner's order. The amount of each medication which had been dispensed during this period was not significantly in excess of the amount of each medication she was required to take.

Comments and Recommendations

Ms Brown was not a well person. It is also clearly evident she had great difficulty looking after herself. It appears these issues in addition to her likely taking too much medication has led to her suffering from hypothermia which has caused her death.

Sadly, Ms Brown's situation is not an uncommon one. Essentially, it appears she has not been able to access the care and medical treatment she required without the assistance of others. That assistance is primarily provided by family and friends. In this case that care was not provided by family and friends because Ms Brown was socially isolated. As well-meaning as organisations like Anglicare are, they are no substitute for the personal and close attention provided to the sick in our community by family and friends.

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[1] The first reported prescription of both these drugs was on 11 July 2013. They were prescribed consistently until August 2019.

[2] The pharmacy records suggest the medication was packaged on a regular basis. Ms Brown was charged for this service on a regular basis which was generally 4 weekly. The 000 call to AT indicates that when Ms Brown was found a Webster pack was also found. A Webster pack contains all the tablets and capsules that need to be taken at each particular time of the day, for each day of the week. This device makes it easier to manage medication. The pharmacist takes the doctor's prescriptions and dispenses the medication into a blister pack for each time of day for each day of the week. Each blister pack is securely sealed so the medication is protected and there is no chance of spilling or mixing medications up.

The circumstances of Ms Brown's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Sandra Anne Brown.

Dated: 21 September 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner