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 Daniel Wayne Dare

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

a) The identity of the deceased is Daniel Wayne Dare (Mr Dare);
b) Mr Dare died in the circumstances set out below;
c) Mr Dare's cause of death was mixed prescription drug toxicity (tramadol and diazepam); and
d) Mr Dare died on 3 February 2020 at Glenorchy, Tasmania.

Introduction

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

- The Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of Dr Donald Ritchey forensic pathologist;
- affidavit of Mr Neil McLachlan-Troup forensic scientist of Forensic Science Service Tasmania – toxicology and analytical report;
- Medical records of Mr Dare obtained from his general practitioner;
- Medical records of Mr Dare obtained from the Royal Hobart Hospital (RHH);
- Medical records of Mr Dare obtained from Community and Rural Health Mental Health Services – South;
- Affidavit of Sandra Robson, Mr Dare's mother;
- Affidavit of Dannielle Benjamin, the partner of Mr Dare;
- Affidavit of Laura – Mae Wilson, the former partner of Mr Dare;
- Affidavit of First-Class Constable Claire Honey;
- Affidavit of Constable Travis Smith;

- Affidavit of Sergeant Michael Bobrowski;
- Affidavit Detective Senior Constable Mark Wilby;
- Affidavit of Detective Senior Constable Kirby Direen;
- Affidavit of Senior Constable Rance Swinton;
- Report of the coronial medical advisor Dr Anthony Bell MB BS MD FRACP FCICM; and
- Photographs and forensic evidence.

Background

Mr Dare was the son of Ms Robson and Mr Wayne Dare. Mr Wayne Dare passed away in excess of 10 years ago. When the relationship between Mr Dare's parents ended Mr Dare did not see his father. Mr Dare has 3 siblings on his mother's side; a sister and 2 brothers, Mr Dare being the youngest. He had a positive relationship with his siblings. He also had half siblings on his father's side however as an adult he had little to no relationship with them.

Ms Robson says Mr Dare's childhood was a happy one. He attended primary school in Tasmania and then in Adelaide prior to the family moving back to Tasmania. When they did so Mr Dare attended school in Gagebrook. Following this he was homeschooled until the conclusion of year 10. He did not enjoy school and he was generally disruptive and disengaged.

During early adult hood Mr Dare was employed as a car detailer for a short period of time. This employment ended when he injured himself which aggravated a back injury which had been sustained in a number of previous motorcycle crashes. Mr Dare also did some casual work which included putting out unit complex rubbish bins on the street the night prior to collection.

Mr Dare is the father of a son who was 6 years of age at the time of Mr Dare's death. The mother of this child is Ms Wilson who had a strained relationship with Mr Dare which had ended approximately 18 months prior to his death. There were frequent disagreements regarding their son's care with Ms Wilson allegedly not wanting her son to see Mr Dare. This is evident from data extracted from Mr Dare's phone and affidavits obtained from Ms Robson and Ms Benjamin.

In the 18 months leading up to Mr Dare's death he was in a relationship with Ms Benjamin. This relationship was a positive one and the 2 had plans to move in together. In addition Ms Benjamin says Mr Dare was planning to purchase her an engagement ring. Ms Robson says that during her son's relationship with Ms Benjamin he was the happiest she had seen.

Medical history

As a child Mr Dare received treatment from Clare House which was part of Community and Rural Health Mental Health Services of the Tasmanian Health Service. He was initially seen in 1996 and 1997. He was re-referred to that service and saw the child psychiatrist, Dr Patrick Fernando, on 20 occasions between 7 November 2000 and 8 November 2002. He saw Dr Fernando again on 28 June 2004. It was noted by Dr Fernando Mr Dare was disruptive both at home and at school. He was thought to be suffering from Attention Deficit Hyperactivity Disorder and he was treated with stimulant medications. Dr Fernando however believed Mr Dare's behaviour was secondary to intellectual and learning difficulties. Accordingly he was permitted to cease his formal education and thereafter his behaviour improved dramatically. It was only when he was reintroduced to academic work that his behaviour deteriorated. Dr Fernando was of the view Mr Dare did not need any medication but rather practical and vocational training; that is a special program rather than the normal school curriculum.

The general practitioner's records cover the period from 13 March 2012 until 28 January 2020. These records and the hospital records reveal Mr Dare was admitted to hospital for 2 days in August 2015 with bronchopneumonia, he was admitted in April 2016 for 2 days after an overdose of medication and he was treated again for an overdose on 24 September 2019. On all those occasions he was taken to hospital by ambulance. He was treated at the Department of Emergency Medicine of the Royal Hobart Hospital in August 2018 for chest pain. There were referrals to the pain clinic of that hospital in 2016, 2017 and 2019 for chronic lower back pain but he was discharged from that service because of his failure to attend appointments.

The general practitioner's records disclose difficulties with anger and depression in 2012 and 2015 and lower back problems as a result of a fall from a bike in August 2015. Tramadol was first prescribed for chronic lower back pain in April 2016 and then in July that year Mr Dare was involved in a motor accident which aggravated his back symptoms. Tramadol was ceased in June 2018 but it was recommenced in August of that year. After the overdose in September 2019 Mr Dare's general practitioner refused to prescribe tramadol in October 2019. Mr Dare was angry. He was not prescribed this medication again until 12 November 2019. He was first prescribed an antidepressant in 2012. On 28 January 2020 there was a long discussion between Mr Dare and his general practitioner about sleep problems and a number of suggested solutions were provided. Certificates of incapacity for work were provided by Mr Dare's general practitioner due to depression, anxiety, right knee and lower back pain for the period between

15 September 2015 and 8 June 2016 and then again from 7 September until 7 November 2016. In addition there were referrals for physiotherapy, radiology and pathology.

Circumstances of Mr Dare's death

During the evening of the 2 February 2020 Mr Dare was present at Ms Benjamin's residence. He briefly left the residence at approximately 11:30 PM to put rubbish bins out at the unit complex nearby and to check on his son who was staying with his mother.

In the early hours of 3 February 2020, after Mr Dare had returned to Ms Benjamin's home, she and Mr Dare went to bed. They slept beside one another in Ms Benjamin's bedroom. Ms Benjamin woke later in the morning and she got up to attend to her children. At approximately 11:30 AM she went to wake Mr Dare however found him to be cold and showing no signs of life.

Ms Benjamin contacted both Ms Robson and Ambulance Tasmania. Paramedics attended shortly thereafter where they found no signs of life. Accordingly attempts were not made to resuscitate Mr Dare. The paramedics then contacted police and reported the death.

Investigation

Constable Smith and First Class Constable Honey were the first officers to attend Ms Benjamin's home having been tasked to attend at approximately 12 PM. They spoke to paramedics and obtained the necessary details. They observed Mr Dare lying on his back in bed and they spoke to Ms Benjamin and Ms Robson. They arranged for an officer from forensic services and detectives from CIB and the mortuary ambulance to attend. Constable Smith also attended Mr Dare's home and seized his medication. After attending to these matters they determined there were no suspicious circumstances nor was there any evidence to suggest another person was involved in Mr Dare's death.

Sergeant Bobrowski arrived after Constable Smith and First Class Constable Honey and was briefed by them. He inspected both Mr Dare and the scene and observe no suspicious circumstances or anything to indicate any other person had been involved in Mr Dare's death.

Detective Senior Constable Wilby from CIB arrived with Detective Direen. They were briefed by Sergeant Bobrowski. They then inspected the home and searched the bedroom in which Mr

Dare had been found. He was examined. His vehicle, which was parked at Ms Benjamin's home, was also searched. Ms Benjamin was spoken to and amongst other things she advised Mr Dare had stayed at her home for the past 3 nights but he normally lived with his mother. All of his medication remained at his mother's home and that's where he took his medication. A search of the bedroom found medication however Ms Benjamin confirmed that belonged to her. Senior Constable Swinton from forensic services attended. Mr Dare was examined and it was observed he had no sign of any suspicious injuries or markings. Police found no evidence to suggest any other person had played a part in Mr Dare's death.

The forensic pathologist Dr Ritchey conducted a post-mortem examination on 4 February 2020. That examination and the results of histology and toxicology led him to conclude Mr Dare died of mixed prescription drug toxicity namely tramadol and diazepam. He noted toxicology testing revealed a markedly elevated concentration of tramadol which is a synthetic opioid which depresses the central nervous system. This testing was also positive for diazepam which is also a central nervous system depressant. He says the combination of both drugs cause central nervous system depression by different biochemical pathways and they can cause death by way of respiratory arrest. It was noted by Dr Ritchey Mr Dare suffered from chronic back pain together with depression and anxiety. I accept Dr Ritchey's opinion.

Ms Robson says in her statement she believed Mr Dare was ordered to take 3 tablets of tramadol a day which she thought was too much. She believed the general practitioner was overprescribing. To the best of her knowledge she says her son struggled with depression but she does not believe he was prescribed medication for that condition which she believed he required. Ms Benjamin voiced similar concerns and she was not sure why he was being prescribed medication he had previously overdosed on.

Given these very legitimate concerns the coronial medical consultant, Dr Bell, was asked to review the medical records and comment upon the general practitioner's prescription of medication. In his report Dr Bell notes Mr Dare's past relevant medical history and the medication which had been prescribed shortly prior to his death which was as follows:

- diazepam 10 mg at night commencing on 28 January 2020; (Mr Dare had previously been prescribed diazepam on 17 September 2019. It had been prescribed for a number of years prior to that date).
- fluvoxamine 50 mg daily last prescribed 26 August 2019; and
- tramadol SR 150 mg twice daily if required.

Dr Bell says having reviewed the notes Mr Dare had consulted his GP for many years. Major difficulties concerned chronic pain for which tramadol was prescribed and insomnia. With respect to the latter condition methods for sleeping were discussed and Mr Dare was prescribed diazepam at night. Diazepam can also be prescribed to treat anxiety and fluvoxamine is an antidepressant. Having considered the records Dr Bell believes the general practitioner's prescribing regime was appropriate. He says the use of tramadol appears to have been reasonable and helpful in the relief of Mr Dare's symptoms. He goes on to say the general practitioner provided a good standard of care and provided an above standard level of documentation with respect to his consultations and discussions with Mr Dare. Dr Bell concludes there was no excessive prescribed dosing. I accept Dr Bell's opinion. Accordingly the concerns raised by Ms Robson and Ms Benjamin are not made out. That is Mr Dare was not prescribed too much tramadol, he was prescribed an antidepressant and he was prescribed medication to assist his sleep.

The question however remains as to whether Mr Dare intentionally suicided or whether his overdose was accidental. Although there were previous suicide attempts and this fact alone can be, of itself, the most significant determinant with respect to whether a person will successfully suicide, I am not satisfied to the requisite standard that this is what occurred in this case. I think it is more likely Mr Dare's overdose and subsequent death was accidental. I say this because on all previous occasions when Mr Dare attempted to end his life the evidence suggests he has contacted someone to discuss his plans. He did not do this on this occasion. Neither did he leave a suicide note. In addition he was responsible for his young son at the time and it was out of character for him to do anything which would impact directly on his son. In addition he was future focused in so far as his relationship with Ms Benjamin and her children was concerned and finally he kept his medication at his mother's home so it could not be accessed by Ms Benjamin's children. In those circumstances he is very unlikely to have intentionally suicided in a home in which they were present.

Comments and Recommendations

In conclusion I find Mr Dare's death arose as a result of an accidental overdose of his prescribed medication. The general practitioner's prescription of medication was appropriate and not excessive.

The circumstances of Mr Dare'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 extend my appreciation to investigating officer First Class Constable Claire Honey for her investigation and report.

I convey my sincere condolences to the family and loved ones of Mr Dare.

Dated: 28 November 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner