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 Germaine Hill

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

a) The identity of the deceased is Sandra Germaine Hill ('Ms Hill');

b) Ms Hill died in the circumstances set out in this finding;

c) Ms Hill's cause of death was mixed drug toxicity; and

d) Ms Hill died between 26 and 27 April 2019 at Glenorchy, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- An affidavit of the Forensic Pathologist, Dr Donald Ritchey;
- Toxicology report prepared by the forensic scientist Mr Neil McLachlan-Troup of Forensic Science Service Tasmania;
- Affidavit of Mr John Hodge the senior next of kin;
- Affidavit of Constable Christopher Lobb;
- Affidavit of Constable Jacob Harris;
- Affidavit of Constable Scott Hartill;
- Affidavit of Detective Senior Constable Simon Vout;
- Medical records and reports obtained from Ms Hill's general practitioner; and

- Forensic and photographic evidence.

Background

1. Ms Hill was born in Hobart, Tasmania on 23 January 1952. She spent the early years of her life living on Bruny Island. Ms Hill married Michael Hayden Hill, with whom she had two children, Jodie and Hayden. Ms Hill was divorced after a number of years however, she remained on good terms with her ex-husband.

2. Ms Hill later formed a relationship with Mr John Hodge. They were in a relationship for 17 years and lived together at the time of her death.

3. Over the years Ms Hill worked primarily as a retail assistant at Coles Supermarket at Glenorchy and New Town. In November 2011, she was involved in a motor vehicle accident (MVA) and sustained a fractured pelvis and soft tissue injuries. These injuries and her other health conditions, which are detailed below, led to her being forced to give up work. Later in life, Ms Hill socialised at the Glenorchy Senior Citizens Club and enjoyed playing cards. At the time of her death she was 67 years of age.

Medical history

4. The medical records obtained from Ms Hill's general practitioner are extensive. Her first consultation disclosed in those records was on 27 April 2007 and the last was on 9 April 2019. It is clear from the records though that her general practitioner, Dr Klonaris, had been Ms Hill's general practitioner since the late 1980s. In summary my view of those records is that Ms Hill was treated promptly and diligently by Dr Klonaris and others at his practice for her numerous conditions. There are many, many referrals to specialist doctors in respect of many of the conditions Ms Hill suffered from and there are many reports from those specialists with respect to her response to treatment and her progress. The records reveal Ms Hill was a former smoker but she ceased smoking in April 2007. She was also a regular drinker, consuming an average of three drinks per night. Mr Hodge however says it was not uncommon for Ms Hill to consume eight or more drinks in one night. Ms Hill was not very active and she did not regularly exercise.

5. In 2009, Ms Hill was diagnosed with Waldenstrom's Macroglobulinaemia (WM). This is a rare cancer that begins in the white blood cells. It is a type of non-Hodgkins lymphoma. The prognosis for this cancer is relatively positive (87% survival rate over 5 years for low-risk groups). Ms Hill required ongoing treatment for this, which

included chemotherapy. Despite treatment, she experienced ongoing pain and neuropathy in her feet for which she took prescribed medication.

6. As mentioned above, Ms Hill was involved in a MVA. The MVA occurred on 17 November 2011. She broke her pelvis in two places and was hospitalised until 6 January 2012. During her period of hospitalisation she underwent treatment and rehabilitation which continued for a number of years after discharge. As a result of the injuries she was unable to work and she required medical treatment. She made claims for scheduled benefits under the provisions of the *Motor Accidents (Liabilities and Compensation Act* 1973.

7. Ms Hill suffered from osteoarthritis and osteoporosis. She required physiotherapy, medication, and yearly injections to manage these conditions.

8. Mr Hodge indicates Ms Hill also suffered from depression for which she was previously prescribed anti-depressants. She stopped taking the anti-depressants approximately two months prior to her death as she felt they were no longer necessary. The records of the general practitioner indicate the dose of the antidepressant which was prescribed was one tablet per day. In the 12 months prior to her death only 2 scripts were filled the last being on 9 October 2018. This appears to corroborate what Mr Hodge has said. Ms Hill also had trouble sleeping and she was eventually diagnosed with insomnia. This required the use of prescribed medication. In so far as the medical records are concerned there is a direct reference to depression and anxiety in the notes for 17 December 2008, that *life is miserable* on 10 March 2010, 11 August 2010, 28 September 2012, 17 December 2012 at which time she was seeing a psychologist, 27 May 2013 but she was refusing to take antidepressants at that time, 23 January 2014, 14 April 2014 at which time the notes describe *marital disharmony and a breakup being imminent* (I note this did not occur), 30 July 2014, 13 August 2014 (where she was told by an insurance company to whom she had made a claim on a policy that she would survive 6 years), and 25 September 2014 at which time she was upset by the termination of her employment. She was also at various times anxious about suffering from a brain tumour and in December 2013 and July 2015 she was worried about suffering from lung cancer. All relevant radiological and pathological tests were carried out and it was determined Ms Hill was not suffering from those conditions. There is an entry for 8 December 2016 in which she is described as being depressed in her relationship because her partner shows her no affection.

9. The records also disclose that over the years she suffered from abdominal pain, back and neck pain, headaches, wrist and right sided chest pain, knee pain, swelling of the legs, hip pain and foot and ankle pain. Again each of these ailments was investigated by the general practitioner and referrals were made to the appropriate specialist if those investigations suggested further treatment was required. There is a record of Ms Hill fracturing 2 metatarsal joints in her right foot, her undergoing a number of gastroscopy and colonoscopy procedures and a right hemi-thyroidectomy.

10. In the year prior to her death, Ms Hill was prescribed lovan (an antidepressant), somac (for ulcers and heartburn), cephalexin (to treat bacterial infections), osteomole (for muscle and arthritic pain), lyrica (to treat neuropathic pain), mobic (a non-steroidal anti-inflammatory), prolia (to treat osteoporosis), and norfloxacin (to treat bacterial infections. In addition, during that same period, Ms Hill was prescribed alepam, which can be used to treat anxiety and which contains oxazepam, and endone which is an opioid prescribed for pain relief and which contains oxycodone.

11. Ms Hill visited her general practitioner very regularly. Her medical records show 167 surgery consultations on a medical practitioner between 2007–2019. This is an average of 13 consultations per year. There are another 40 attendances during that period either on nurses at the practice or on administrative staff. Ms Hill attended her general practitioner more times than any other year in 2009, 2012 and 2013. In 2017 her consultations amounted to 8, they fell to 5 in 2018 and she attended the general practitioner on one occasion in 2019.

12. In the five years prior to her death, the main reasons for Ms Hill visiting her general practitioner were foot pain (including a foot fracture in 2018), ear pain, neuropathy in her feet and lower legs, cellulitis, depression, arthritis, insomnia, sinusitis, tinnitus, and gastro-oesophegael reflux disorder.

13. In 2017, Ms Hill raised concerns with her general practitioner about her forgetfulness, citing concern that she was developing dementia. Her general practitioner conducted a test soon after. The results of this test showed Ms Hill was not displaying signs of dementia. Ms Hill's patient health summary lists the following warning: 'WANTS TO HAVE DEMENTIA."

Circumstances of Ms Hill's death

14. On 26 April 2019, Ms Hill spent the morning at home before going to the Glenorchy Senior Citizens Club at 13:00 hours to play cards. Ms Hill returned home around 15:15 hours. She and Mr Hodge made coffees and Ms Hill prepared dinner. Mr Hodge describes Ms Hill as being *"in a good mood for most of the day."*

15. After dinner, Ms Hill and Mr Hodge watched a movie before watching the football. They were both drinking alcohol. Ms Hill consumed approximately eight cans of beer.

16. At around 22:00 hours, Ms Hill and Mr Hodge had a disagreement about his choice of clothing. He was wearing denim jeans and Ms Hill wanted to know why he had not changed into something more comfortable given the late hour. Mr Hodge decided to go to bed because of the disagreement, leaving Ms Hill in the lounge room. A short time later, Ms Hill went to the bedroom to see Mr Hodge. They spoke briefly, she gave him a kiss, and she apologised for arguing with him. Mr Hodge says Ms Hill did not appear upset at this time. She told him she was going to stay up and watch the football game. Mr Hodge fell asleep after this conversation.

17. Ms Hill woke Mr Hodge a short time later and told him the outcome of the football game. She then told him she was going to stay up a bit longer. He then went to sleep and did not wake until the morning.

18. At around 07:00 hours on 27 April 2019, Mr Hodge awoke to the sound of the television still on in the lounge room. He got out of bed and walked to the lounge room at which time he found Ms Hill slumped forward in a recliner chair with vomit spilling from her mouth and onto her jumper. Mr Hodge called triple zero immediately. He was instructed by the communications operator to put Ms Hill on the floor and attempt CPR. He did so. Paramedics arrived at the address a short time later. They declared life extinct at 07:55 hours.

Investigations

19. Constables Lobb and Harris received a call to attend Ms Hill's home at 07:30 hours arriving a short time later. They spoke to the attending paramedics who gave them an initial summary of their observations and actions at the scene. The forensics officer, Constable Hartill, arrived at 08:55 hours and received a briefing from Constables Lobb and Harris. Subsequently, Detective Senior Constable Vout from Glenorchy CIB was tasked to attend Ms Hill's home at 10:00 hours. On arrival he was briefed by

Constable Lobb.

20. The attending police officers observed Ms Hill in the lounge room, on her back, on the floor. They observed that there was vomit on her jumper and there was a plastic bucket on the floor next to her. Mr Hodge says this bucket was not there when he left the room to go to bed the night before. Police did not identify any signs of disturbance, forced entry or foul play. The residence was tidy and it was determined there was nothing suspicious at the scene. They then spoke to Mr Hodge who gave an account of the events leading up to finding Ms Hill and his actions after that.

21. Police searched the lounge room and found a white envelope with a handwritten note in the corner of the recliner chair. The note referenced the difficulty of living with depression.

22. During their search Police located Ms Hill's medication on the kitchen bench. Mr Hodge noticed that her sleeping pill container was completely empty. Mr Hodge says Ms Hill normally took half a sleeping tablet most nights to help with her sleep. Police examined the rubbish bins in the backyard and found a large quantity of empty sleeping pill packets and another handwritten note. This note referenced the argument between Ms Hill and Mr Hodge the night before. Neither of the notes found by police made explicit reference to suicide or suicidal ideation. They did make reference to the difficulty of living with depression and other life stressors.

23. Police observed, while Ms Hill was in situ, the letters 'DNR' were written in pen on the left side of Ms Hill's upper chest. This was believed to be an acronym for 'Do Not Resuscitate.' Detective Senior Constable Vout found no suspicious marks or bruising on Ms Hill's body and that finding together with Constable Hartill's examination of the scene and of Ms Hill, led police to determine there was no evidence to suggest that any other person had played a part in Ms Hill's death. I accept that determination.

24. Police obtained an affidavit from Mr Hodge at the scene. He told them about the events of the previous night including details about the argument he had had with Ms Hill, and the circumstances leading up to him finding her that morning. Mr Hodge said Ms Hill had otherwise seemed happy in recent months and they had not had any major relationship problems. He advised Ms Hill had never made threats or attempted self harm previously and her passing was unexpected.

25. While police were at the scene, Mr Hodge checked his phone and noticed there was a text message from Ms Hill. He did not read the text message in its entirety but it was photographed by Constable Hartill. The text was sent after Mr Hodge had retired to bed on 26 April 2019. The text message did not specifically refer to suicide but I infer from its contents Ms Hill was saying farewell to Mr Hodge, that her ailments were too much to cope with on her own and *"unfortunately [she] needed more."*

26. The forensic pathologist, Dr Ritchey, performed a post-mortem examination on 29 April 2019. Dr Ritchey's opinion on the cause of Ms Hill's death is mixed prescription drug toxicity (oxycodone and oxazepam). A significant contributing factor was depression. Dr Ritchey did not find any evidence of violent injury. At autopsy, he found evidence of central nervous system (CNS) depression; that is a slowing down of the central nervous system. Dr Ritchey says:

> *"Toxicology testing of samples obtained at autopsy revealed a fatal concentration of oxycodone (a synthetic opiod analgesic that is a strong CNS depressant) and an elevated concentration of oxazepam (a benzodiazepine class drug that is also a CNS depressant). The toxicity of both these drugs is greatly enhanced when taken together resulting in death by a mechanism of respiratory arrest due to CNS depression."*

27. Toxicological analysis determined Ms Hill had a blood alcohol concentration of 0.049g of alcohol in 100 mL of blood. Oxycodone was detected in the reported toxic and fatal range whereas oxazepam was detected in the greater than therapeutic range. Mr McLachlan-Troup says that in addition to these 2 CNS depressants alcohol, which is also a CNS depressant, was detected. Symptoms of CNS depression include feeling sleepy and uncoordinated, staggering, blurred vision, impaired thinking, slurred speech, impaired perception of time and space, slowed reflexes and breathing, decreased heart rate, reduced sensitivity to pain and loss of consciousness possibly leading to coma or death at the most extreme end. He says in combination with other CNS depressants such as oxycodone and alcohol the sedative effects of oxazepam will be enhanced.

28. Ms Hill's medical records show she was assessed for drug seeking behaviour on each occasion that Endone was prescribed. On each occasion, she was not assessed as meeting the test for drug seeking behaviour.

29. Photographs taken by forensic officers show that there were packets of endone tablets (containing oxycodone 5mg) and serepax (containing oxazepam 30 mg), which were presumably dispensed in substitution for alepam, at Ms Hill's residence at the time of her death. One empty 10-pill blisterpack of endone was located in the rubbish bin. Two empty 15-pill blisterpacks of serepax were also located in the rubbish bin. Packets of other medications were also located. In so far as alepam was concerned, the records show that approximately 500 tablets were prescribed in the 14 months prior to Ms Hill's death, the last prescription is dated 9 April 2019, whereas only 60 tablets of endone were prescribed in the 12 months prior to Ms Hill's death with the last prescription dated 4 October 2018. The dose of each drug remained the same from the time it was first prescribed namely 0.5-1 tablet of alepam prn (as required) and 1 – 2 tablets 4 times per day of endone prn. Assuming Ms Hill consumed those medications on a daily basis then she would have had a quantity of alepam available to her at the date of her death but she would have used up her endone by that date. I can only therefore conclude that, at least in so far as endone is concerned, she had not been taking it regularly and had a supply of endone as at the date of her death. I find that there was nothing untoward in the prescription of these medications or the rate at which they were prescribed.

30. I am satisfied Ms Hill died as a result of self-induced mixed prescription drug toxicity. I conclude that, between 26 and 27 April 2019, Ms Hill self-administered an overdose of endone and serapax tablets with the intention of ending her life. The medications detected in the toxicological testing match medications found at Ms Hill's residence. The two notes and one text message left by Ms Hill indicate she was depressed and she was struggling with her personal relationship and medical ailments and I infer from the contents of those documents she intended to end her own life. The inscription of 'DNR' on her chest in pen further satisfies me of Ms Hill's suicidal intent. I note Mr Hodge was not aware of Ms Hill having attempted suicide previously or having suicidal ideation. However, he was aware Ms Hill had ceased taking her anti-depressant medication two months before her death and it is therefore likely she experienced a worsening of depressive symptoms as a result.

Comments and Recommendations

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

Acknowledgements

32. I extend my appreciation to investigating officer Constable Christopher Lobb for his investigation and report.

33. I convey my sincere condolences to the family and loved ones of Ms Sandra Hill.

Dated: 20 September 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner