MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of DQ

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

a) The identity of the deceased is DQ, date of birth 17 June 1968.

b) DQ was 54 years of age, divorced and resided in Oakdowns. She had three children to former husband, LO. She subsequently entered into a relationship with HY and took his name. DQ had held numerous forms of employment, including working for Inghams Chicken, Australia Post and the Lillian Martin Nursing Home. DQ had significant problems with substance addiction, primarily opioids, for many years before her death.

DQ re-partnered with HY and, in 2009, relocated to South Australia with him. In September 2009, HY died as a result of a drug overdose. DQ then returned to Tasmania, purchasing a property in New Norfolk. At this time, she attempted to address her drug addiction and took part in an opioid replacement treatment program. Through this treatment program, DQ met Shaun Fenton, and the couple became close for a period of 20 years.

In around 2017, DQ purchased a property in Oakdowns, seeking to move closer to her children and grandchildren. Though she struggled with her addiction DQ went through periods of recovery and was able to resist use of illicit drugs for periods of time. DQ's battle with addiction involved her sourcing illicit drugs (amphetamines and cannabis) and controlled medication (Xanax, morphine and Valium) from street suppliers. Additionally, the credible affidavit evidence from those close to DQ allows me to conclude that she regularly injected her methadone, a dangerous practice, rather than ingesting it orally as prescribed. I also find that she

regularly double (and even triple) dosed her methadone, by using takeaway doses for future days.

Mr Fenton stated in his affidavit for the investigation that DQ had passed out to a state of unconsciousness as a result of excessive substance use on several occasions in the six months before her death. He said that, on those occasions when he found her in that state, he would help her to her bed or the couch and ask her neighbour, Rosalie Honner, to check on her.

Specifically, the evidence indicates that in March 2022, DQ ingested an excessive quantity of diazepam requiring a hospital presentation with follow-up by her general practitioner, Dr Paul Thompson. Dr Thompson had been DQ's general practitioner for approximately three years and was responsible for her opioid replacement therapy and prescribing.

In June 2022, about four months prior to her death, DQ did not respond to Ms Honner and another friend, Gabrielle Menzies, knocking on her front door and bedroom window. Ms Honner used the spare key given to her by DQ to gain access inside her house. They found DQ unconscious next to the kitchen bench and she appeared blue in colour. Ms Menzies performed CPR and an ambulance was called. She regained consciousness and was treated by ambulance paramedics, before being admitted to hospital overnight. Dr Thompson was notified of the hospital admission.

On the morning of 16 October 2022, Ms Menzies and Ms Honner again arrived at DQ's address as DQ had not responded to messages from Ms Menzies the previous day. They could not elicit a response from her by knocking on her door and bedroom window. As occurred on the previous occasion, they used the spare key to gain entry into the house. When they did so, they located DQ unresponsive on the floor, apparently deceased. They immediately called emergency services.

Police officers and ambulance paramedics attended the address. The paramedics determined that medical intervention was not required and that DQ was deceased.

Upon examination of the scene, the attending officers found no suspicious circumstances implicating any other person in the death of DQ. They did locate two empty plastic containers labelled as "80mg Methadone" on the shelf in the kitchen. These containers were labelled with the dates 16

October 2022 and 17 October 2022 and were the takeaway doses prescribed by Dr Thompson for those days.

A clear syringe containing an unknown liquid was located in the door of the refrigerator. No hypodermic needle was attached, and no label identified the substance. Numerous small yellow paper envelopes were found within a dresser drawer in the master bedroom. Three of the envelopes were labelled as “5mg diazepam take TWO in the evening” and all were empty.

c) At autopsy, the forensic pathologist found the cause of death to be mixed drug (methadone and diazepam) toxicity. The toxicology report relied upon by the forensic pathologist revealed that methadone was present in DQ’s blood within the reported fatal range. Although individual tolerance must be taken into account, the evidence indicates that DQ consumed triple her prescribed dosing quantity on Saturday 15 October 2022. This likely involved her injecting both of her additional takeaway doses that day in addition to her pharmacy dose. Together with consuming diazepam, death occurred as a result of combined central nervous system depressant effects of both substances. While DQ had consumed an excessive amount of methadone, I find that it was not her intention to end her life. Her death was accidental in nature.

d) DQ died between 15 and 16 October 2022 at Oakdowns, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinion of the forensic pathologist;
- Toxicology report of Forensic Science Service Tasmania;
- Medical records of Tasmanian Health Service;
- Medical records of Churchill Avenue Medical Centre;
- Pharmaceutical Services Branch (PSB) report;
- Report from Forensic Mental Health Services;
- Affidavit of TY, son of DQ;
- Affidavit of Gabrielle Menzies, friend of DQ;
- Affidavit of Rosalie Honner, neighbour and friend of DQ;
- Affidavit of Kelsey Goodman, friend of Ms DQ;

- Affidavits of attending and investigating police officers, together with scene photographs and body worn camera footage;
- Tasmania Police records;
- Laboratory report of Forensic Science Service Tasmania relating to contents of a syringe found at the scene;
- Report of Forensic Nurse, Mr Kevin Egan; and
- Report from Dr Paul Thompson for the coronial investigation.

Comments and Recommendations

DQ was well known to be opioid dependant, with a long history of illicit drug abuse. Because of her dependency, she had for many years participated in opioid replacement therapy. Since 2019, her general practitioner, Dr Paul Thompson, had supervised her program, involving prescribing oral methadone liquid. Prior to that time, since 2016, DQ had been prescribed buprenorphine/naloxone, known to be a safer opioid replacement. Dr Thompson also prescribed diazepam, a benzodiazepine, with the methadone syrup. He ordered that DQ have her methadone dispensed at a pharmacy on Tuesdays, Thursdays, Fridays and Saturdays. On the other days, including the consecutive weekend days, she received “takeaway” doses for consumption at home.

I am satisfied, including by the evidence at autopsy, that DQ regularly injected her prescribed takeaway doses, which were intended for oral ingestion. I am also satisfied that she illicitly sourced other substances, including morphine. In the months before her death, she was at particular risk of harm by drug misuse.

I received a helpful report for this investigation from the Chief Pharmacist on behalf of PSB outlining much of DQ’s long history of opioid addiction and treatment (“the PSB report”).

The particularly salient issue discussed in the PSB report was that DQ had two documented non-fatal poisoning events in the year of her death – one involving prescribed benzodiazepines and a second involving excessive consumption of her methadone takeaway doses. PSB commented that Dr Thompson continued to prescribe DQ methadone takeaway doses at the same level immediately following both poisoning events. This therefore gave her the opportunity to inject two consecutive takeaway doses totalling 160mg (80mg for each dose) every week.

Therefore, following these events, PSB suggests that Dr Thompson did not apply appropriate mitigation strategies to decrease the risk of a further poisoning event.

In particular, the PSB report questioned whether Dr Thompson created a documented risk-benefit assessment to determine if the continued prescribing of high-risk substances to DQ remained appropriate. Associated with this apparent lack of documentation, PSB further questioned the lack of detailed risk mitigation strategies implemented by Dr Thompson to minimise the potential for patient or public harm. These should have included:

“• *Consistent and high frequency staged-supply conditions of all high-risk prescription substances*
- *Removal or further restriction of the number of take-away doses of methadone prescribed*
- *Consideration of changing treatment for opioid use disorder to a safer formulation, such as buprenorphine*
- *Frequent unannounced and supervised urine drug screens*
- *Frequent full body checks for any signs of injecting stigmata*
- *Treatment agreement with patient documenting treatment goals, review periods and clear indicators for treatment failure and the need to cease a medication*
- *Frequent clear, open, and transparent communication with other health professionals (e.g. pharmacists, other prescribing medical practitioners) responsible for the care of this patient*
- *Prescribing the lowest effective dose for the shortest possible time, in-line with current therapeutic guidelines*
- *Provision of naloxone to DQ and her close circle of friends and family that may be present if she was experiencing an opioid poisoning event (overdose) – this supply should also have included appropriate counselling on when and how to administer the naloxone*”.

Other issues arising from the PSB report and from a review by the coronial nurse, were the lack of engagement by DQ with other specialist health services; the fact that Dr Thompson was not accredited to prescribe buprenorphine/naloxone; that Dr Thompson did not restrict supply upon receiving information that DQ was selling her methadone; and the fact that DQ continued to be prescribed a benzodiazepine concurrently with her methadone.

The PSB report further emphasised the requirements for methadone prescribers to adhere to the Tasmanian Opioid Pharmacotherapy Program (TOPP) policy and clinical practice guidelines, being referred to in the authority to prescribe.

PSB considered that Dr Thompson did not adhere to the TOPP guidelines by: authorising more than two takeaway doses per week for DQ, authorising consecutive takeaway doses, authorising takeaway doses at times when she was not clinically stable (including missed doses of medication and poisoning events from prescribed substances), and authorising takeaway doses while she was being prescribed medium to high doses of benzodiazepines.

I have received a report from Dr Thompson seeking his response to the above issues raised in this investigation. In his comprehensive report, he outlined his knowledge, experience and accreditation in methadone prescribing and his current high patient numbers caused by a shortage of accredited general practitioners.

In summary, Dr Thompson reported as follows:

- He assessed DQ to be clinically stable on her dose of prescribed methadone, including the weekly takeaway doses.
- He attempted to reduce DQ's ongoing use of diazepam but, noting that she had been taking it for a long time before he commenced treating her, she was unable to reduce it. Nevertheless, he discussed with her the risks associated with the combination of diazepam and methadone.
- He regularly checked DQ's skin due to her widespread dermatitis. It was his practice to note any injection sites. He did not note any and he did not recall finding any evidence of intravenous drug use.
- He received three messages at his practice from females advising that DQ was either selling or swapping methadone and was buying illicit morphine. He attempted to contact those callers but could not be connected to them. Upon questioning DQ, she denied the allegations.
- He did perform one unannounced urine drug test on 25 March 2021 (following the unverified reports of selling or swapping drugs) which returned the result of only methadone.
- DQ told him that the overdose of diazepam occurring on 15 March 2022 was, in fact, a situation where she had been deliberately drugged by an acquaintance who had then stolen money from her.
- In relation to the takeaway methadone overdose of 14 June 2022, DQ told Dr Thompson that it was the first time it had happened and assured him that this would not happen again. In light of her stability, lack of prior misuse and the explained drink-spiking episode, he felt it was unnecessary to modify her treatment. He explained that *"there was not even a single*

episode in 3 years of the common takeaway behaviours that would alert me to takeaway abuse or diversion".

- DQ told him she preferred methadone to Suboxone, but he would have referred her to an alternative practitioner for Suboxone if she had wished, as he had done with other patients. He stated that being accredited to issue only one type of therapy was not a barrier to a patient accessing alternatives if they wished to trial other opioid replacement therapies.
- He performed risk-benefit assessments for every medication he prescribed in his consultations. He did not consider treatment agreements to be effective.
- He regularly was in contact with pharmacists, including Lauderdale Pharmacy which dispensed for DQ, in instances where she had missed doses.

More broadly, Dr Thompson described his general approach to opioid replacement therapy and the risks associated with individual participants. He described his strict policy that takeaway doses will not be replaced for any other reason apart from exceptional circumstances. He noted that the Tasmanian TOPP guidelines are stricter in limiting takeaway doses to two per week than other jurisdictions, and there are important reasons for stable patients to normalise their lives by reduced frequency of supervised dosing. He particularly noted that DQ was living in an area where daily travel to a pharmacy was difficult. He also referred to an underlying discretion, despite the guidelines, for prescribers to vary takeaway dose arrangements for patients. Dr Thompson stated that he has never been contacted by any regulatory body regarding deviations from the policy that his provision of more than two takeaway doses per week to a patient was unacceptable. I accept his evidence that more than two takeaway doses per week is a widespread practice amongst methadone prescribers.

Dr Thompson, following the death of DQ, reviewed all of his methadone patients, stating:

> *"Doses, were (sic) possible, are being reduced, concurrent medications are being audited and revised were (sic) necessary. Benzodiazepines particularly will be used in the smallest dose possible if clinically indicated. All other CNS depressants have and will be treated in a similar fashion.*
>
> *I have read all opioid treatment guidelines from Tasmania, Victoria, New South Wales, Queensland and Western Australia to ensure that my knowledge and practice is up to date with current guidelines. I am also going to regularly review these sites and undertake CPD activities online.*

I undertake to train in all products registered by the TGA for the treatment of opioid substance use disorders. These products include Suboxone, Depot buprenorphine and naloxone".

I accept that Dr Thompson was an experienced practitioner in opioid replacement therapy and that he treated DQ in good faith, believing that his risk assessment and mitigation strategies were appropriate in the circumstances.

I also bear in mind that Dr Thompson treated DQ for only three years, a short time in the context of her treatment for use disorder over many years. In that situation, Dr Thompson faced an extremely difficult task in weaning DQ from her long-term use of benzodiazepines and I doubt that he could have persuaded her to switch to a safer opioid replacement.

I also accept that DQ presented to him without many of the usual signs of misuse of drugs. I also understand that the manner of his treatment, prescription of takeaway doses, (including on two consecutive days) and management of DQ was not at significant variance with treatment provided by other methadone prescribers. However, in the period prior to her fatal unintentional poisoning, it could not be said that DQ was clinically stable such that takeaway doses, at least on consecutive days, should have been continued. A documented reassessment of risk should also have occurred. Increased vigilance by way of possibly decreasing the dose (which had recently been increased), documented checking for intravenous use, increased urine testing and investigation regarding misuse, should also have occurred. A referral to an addiction specialist or alcohol and drug services should also have been considered and more forcefully pursued.

The PSB report notes that DQ's death draws attention to the disproportionately high poisoning deaths in Tasmania related to methadone syrup compared to other treatments for opioid use disorder, namely those containing buprenorphine. It is less likely that DQ's death would have occurred had she not had access to two takeaway doses of methadone. I accept that Dr Thompson was shocked that DQ had taken this action and indicated that she was aware of the risks as a long-time opioid user.

I cannot find that Dr Thompson's management of DQ so deviated from accepted practice that he could be said to have actually contributed to her death. However, in hindsight, there were warning signs that required him to take more restrictive measures to prevent DQ from being a risk to herself. If he had reduced her takeaway doses, she may not have died. However, she may well also have sourced drugs from other means, such was the extent of her addiction.

I recognise also that Dr Thompson is one of a decreasing pool of medical practitioners prepared to engage in the very difficult but important area of opioid pharmacotherapy.

I recognise that he has undertaken to train in all products registered by the TGA for treatment of opioid substance use disorders and has taken steps to review his practices where indicated.

General comments regarding methadone prescribing

Unfortunately, coroners are regularly required to investigate the connection between apparently excessive numbers of prescribed takeaway methadone doses and a person's death by methadone poisoning.[1] Often, these cases involve several aspects of departure by the prescribing medical practitioner from the TOPP guidelines. Although the guidelines do not have legal force, they represent the current clinical practice standards for the delivery of opioid pharmacotherapy for the treatment of opioid dependence in Tasmania.

Coroners have also consistently recognised the complexities for medical practitioners in the delivery of opioid pharmacotherapy. Medical practitioners, almost invariably, seek to deliver careful and effective treatment to their patients.[2] However, issues may arise because of the nature of addiction, the desires of the patient, and the relationship of trust between patient and doctor.

Despite the difficult nature of this area, it is critical that any decision made by a medical practitioner to prescribe takeaway doses of methadone is continuously reviewed by clinical assessment and by objective consideration of information provided by the patient and all other sources, and also by regular urinalysis. Analysis of such information may well change the assessment of clinical stability and therefore the risk of harm to the patient and public safety if continued takeaway doses are prescribed.

It has also been recognised by coroners that medical practitioners require ready access to specialist review, advice and support at critical times in the course of treating patients receiving opioid pharmacotherapy.[3] Again, this may be difficult

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[1] See Inquest into the death of Paul Lowe (Lowe, Paul 2021 TASCD 684) and Finding in the death of Christopher Adams (Adams, Christoper Neil 2020 TASCD 253).
[2] See Finding in the death of Timothy Wellington (Wellington, Timothy John 2020 TASCD 474) and Lowe, Paul 2021 TASCD 684 and Finding in the death of Deearne Barnes (Barnes, Deearne Joan 2016 TASCD 179).
[3] See Barnes, Deearne Joan 2016 TASCD 179.

because of lack of available support, insufficient time and the reluctance of the patient to engage.[4]

I note that it is the role of Alcohol and Drug Services to provide clinical support for medical practitioners.[5] This may involve assistance on assessment of clinical stability, the appropriate prescribing of takeaway doses of methadone and the transfer of a methadone patient to a safer opioid replacement (such as Suboxone). In preventing further deaths connected to prescribed methadone takeaway doses, it remains critical that treating medical practitioners consider these matters on an ongoing basis together with the standards set out in the TOPP guidelines.

In concluding, I extend my appreciation to investigating officer Senior Constable Matthew Duncan for his investigation and report.

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

Dated: 2 December 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner

[4] See Wellington, Timothy John 2020 TASCD 474.
[5] See Lowe, Paul 2021 TASCD 684.