MAGISTRATES COURT TASMANIA

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 SH

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

a) The identity of the deceased is SH, date of birth 15 December 1965.

b) SH was 57 years of age and lived alone in a unit in New Town. She had never been married and did not have children. Her parents are deceased. Her surviving family members include her sister, RT, and her brother, KN. SH maintained close female friendships, including with AX. Recently before her death, her employment at Mental Health Services in administration had been terminated as a result of her very poor mental and physical health and ongoing sick leave requirements. Shortly before her death, she had applied for bankruptcy, stating in the application that her debt was $41,786.

SH had a very complex medical, mental health, social and employment history. Her medical records include diagnoses of depression, obsessive-compulsive disorder, agoraphobia, opioid addiction, severe chronic pain, hypothyroidism, chronic nausea and constipation, epilepsy, type II diabetes mellitus, diverticular rupture, hernia, and osteoarthritis. In addition to her drug dependence, SH also consumed alcohol to excess and smoked cigarettes.

She was under the care of her general practitioner, Dr Paul Thompson, who prescribed medication for her numerous conditions. Relevantly, these included antidepressants, an antipsychotic, antiemetics, and pain medications. SH was also a long-term participant in the opioid pharmacotherapy program whereby she was prescribed daily doses of oral

methadone, an opioid replacement. Since 2019, SH's physical and mental health further declined, as I detail below. Following abdominal surgery and complications, her pain levels became intolerable and she was significantly incapacitated in her daily functioning.

On the evening of 28 June 2023, SH was at AX's residence consuming alcohol. She became somewhat intoxicated and was also taking ibuprofen, Panadol and Maxolon. At about 6.15pm, AX arranged a taxi home for her. She spoke to SH on the phone at 9.45pm that evening, stating in her affidavit that SH *"sounded drunk".*

Early the following morning, 29 June 2023, AX tried to make phone contact with SH. She did not answer. At approximately 9.00am, a representative from Community Transport arrived at SH's residence for a scheduled pickup. After receiving no response at the door or by phone, the Community Transport representative contacted police with concern for the welfare of SH.

At 10.21am police officers attended the residence. They also met AX at the front door. She had come to take SH to a doctor's appointment and had obtained a spare key from SH's long-term neighbour but was unable to enter due to the presence of a security chain. The attending officers removed the chain and entered the premises, where they found SH deceased on the couch. The residence was cluttered and messy. SH was lying on her right side, arms near her chest, with holding a teddy bear. There was visible discharge from her nose. Three empty bottles of her prescribed methadone syrup were found on the floor near where she lay. The television was on. Other empty bottles of methadone, medications and medication packets were located by the attending officers in various places. There was no documentation or other evidence located in her unit, including on her phone, to indicate that her death was as a result of suicide. There was also no indication of suspicious circumstances or that any other person was involved.

c) An autopsy was conducted upon SH, following which the State Forensic Pathologist concluded that SH died as a result of aspiration of gastric contents caused by mixed drug and alcohol toxicity. Apart from evidence of aspiration, the State Forensic Pathologist saw no other anatomical cause of death. Toxicological testing of post-mortem samples, however, indicated that SH had a blood alcohol level of approximately 0.15 g/100mL

and had numerous prescription drugs in her system, including methadone. A benzodiazepine, alprazolam, was also present in the sample. This substance was not prescribed to SH, and it is likely that she obtained it illicitly. Attending police officers retrieved two “clip lock” bags containing two yellow and two white unknown tablets, strongly suggesting that SH was seeking substances outside those prescribed by her general practitioner.

I accept the opinion of the State Forensic Pathologist as to cause of death and find that SH died as a result of combined drug and alcohol toxicity which resulted in respiratory depression. It is not possible to determine whether the quantities of prescribed medications taken before her death were consistent with or exceeded the specified doses. It is also not possible, specifically with respect to methadone, to determine whether she consumed more than her single daily dose. Dr Thompson prescribed SH four takeaway methadone doses per week, but pharmacy records indicate that she had only been given one of her weekly takeaway doses on 27 June 2023 for consumption the following day. It is possible that SH stockpiled takeaway doses from previous weeks and ingested more than one dose prior to her death. This cannot be ascertained.

d) SH died between 28 and 29 June 2023 at New Town, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinion of the State Forensic Pathologist, who conducted the autopsy;
- Toxicology report of Forensic Science Service Tasmania;
- Affidavits of AX, friend of SH;
- Affidavit of EY, friend of SH;
- Statutory declaration of UY, friend of SH;
- General practitioner records;
- Statutory declaration of pharmacist, together with pharmacy records;
- Report to Coroner from general practitioner, Dr Paul Thompson, dated 29 June 2025;
- Affidavit of two attending and investigating police officers (including a forensics officer) together with scene photographs;

- Report from Professor Kate Burbury, Executive Director of Medical Services and Research Hospitals South concerning the Persistent Pain Service guidelines and SH's referral to the Persistent Pain Service;
- Case review by the Coronial Nurse, Kevin Egan; and
- Bankruptcy and other paperwork located at the scene belonging to SH.

Comments and Recommendations

In this case, I considered it important to examine whether there were any deficits in the treatment or management of SH by Dr Thompson that may be connected to her death. To assist with this issue, I requested a review by the Coronial Nurse, Kevin Egan, of the records of Dr Thompson and other relevant investigation material.

Mr Egan produced a report in which he expressed the view that there were no significant deficits in Dr Thompson's management of SH and that the prescribing of medications to her was appropriate. Mr Egan concluded that SH *"was a very complex and difficult patient to manage due to chronic pain, chronic health conditions…, previous addiction, opioid replacement and difficult and complex social, financial and employment stressors".*

Dr Thompson provided a detailed report for the coronial investigation. In that report, he said that, until November 2019, SH had been a well-motivated patient, working full-time and dealing well with her multiple physical and mental problems. She then suffered a ruptured sigmoid diverticulum with peritonitis requiring emergency surgery, including a bowel colostomy. Following that time, she experienced severe abdominal pain together with a worsening of her mental health with suicidal thoughts. She did not engage with her psychiatrist and chronic ankle pain limited her walking ability. Her pain and general health condition deteriorated further in August 2021 when she underwent surgery to reverse her colostomy and also to repair three hernias. She developed a severe wound infection with ongoing symptoms. Consequently, her requirements for opioid analgesia escalated.

Dr Thompson described SH's abdominal surgeries in 2019 and 2021 as "*disastrous",* particularly in respect of the infection from the second surgery which was the "*worst wound infection"* he had encountered.

Dr Thompson said in his report:

> *"Having developed this infection she was prescribed very high doses of oxycodone and tramadol that destabilised her methadone use. Controlling her use of these medications was problematic and it took many months to control*

and ultimately cease her use. Escalation of her methadone dosage was the only method of control available.

The number of takeaway doses allowed was high. This was discussed with Pharmaceutical Services Branch who agreed with three pickups weekly of her medication. An extra takeaway was given due to COVID, SH's immune compromise, her inability to walk any distance due to her left ankle and foot pain, her lack of transport to and from the pharmacy (no drivers licence or car), and her agoraphobia".

Dr Thompson described his efforts to implement staged medication pickups and to reduce SH's opioid requirements, particularly in the year prior to her death. He also detailed the referrals he made to numerous other health professionals, including a psychologist in respect of SH severe anxiety, stress and depression. He also noted that SH was supported by her rehabilitation provider.

Dr Thompson said that, in March 2023 he referred SH to the Persistent Pain Service at the Royal Hobart Hospital but that she was not accepted as a patient with that service. Having received a report in this investigation from the Executive Director of Medical Services Hospitals South, it is clear that the treatment proposed for SH by Dr Thompson (ketamine infusion) was not a treatment that could be delivered by the service and that SH, as a person receiving opioid substitution therapy, was also ineligible on that basis.

Dr Thompson further reported that in May 2023, SH had an accidental fall and sustained a metacarpal fracture of the right hand. Dr Thompson described this as a major setback for her, leading to significant destabilisation of her chronic pain syndrome. Following this injury, SH told Dr Thompson that her methadone was only providing three hours of relief and that she was unable to do anything, including showering or looking after her pet birds. Dr Thompson said that he counselled her on the need to reduce her methadone dosages and other medications, but she was resistant to this proposal. Dr Thompson did not accede to her requests for additional analgesia. He said SH told him that she had reduced her alcohol intake. It appears from his report that Dr Thompson did not consider that SH was consuming alcohol at dangerous levels.

Having considered Dr Thompson's report, Mr Egan's report and the medical records, I fully accept the very difficult task faced by Dr Thompson in treating SH with her many debilitating conditions and severe pain. It is apparent that he was most attentive to her care and vigilant to the need to reduce her significant opioid

analgesia. I observe that SH was successfully weaned from tramadol and oxycodone. Mr Egan stated that the records indicate that Dr Thompson was an engaged general practitioner, who set boundaries for prescribing, and engaged with external clinical and mental health support resources. Mr Egan noted that he often refused additional requests for more opioid or other strong pain prescriptions made by SH. He commented that SH engaged only to a limited extent with those health professionals to whom she was referred for ongoing care and management.

I find that Dr Thompson, for the reasons set out above, was diligent in his management of SH and did his best to treat her very complex conditions.

However, a comment is required regarding Dr Thompson's prescribing of methadone takeaway doses to SH. As discussed earlier, methadone contributed to SH's respiratory depression and death.

In accordance with the guidelines set by the *Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards 2012,* patients are eligible for methadone takeaway doses when there is clear evidence of clinical stability. Two methadone takeaway doses per week is the maximum number approved by the guidelines, which are administered by the Tasmanian Alcohol and Drug Services.

Contrary to these guidelines, Dr Thompson prescribed four takeaway doses of methadone on a weekly basis to SH. Further, she may well not have been deemed clinically stable. I do note that a statutory declaration was provided by the pharmacist in charge of SH regular dosing pharmacy. The pharmacist stated that SH never missed a dose and did not ever present as being in an unfit state to receive her daily dose together with her prescribed takeaway doses. Injecting paraphernalia was not found at the scene and there is no evidence to suggest that she injected her methadone takeaway doses.

Ideally, Dr Thompson should not have allowed SH four takeaway doses of methadone per week. However, the evidence does not permit a conclusion that SH generally misused her methadone or that she had consumed more than her daily dose before her death. The same outcome may have occurred if SH had taken her dose for 28 June 2023 at the pharmacy. It is therefore not appropriate to examine this issue in more detail, except to observe that methadone, a central nervous system depressant, is regularly found by coroners to be a contributor in unintentional deaths involving drug toxicity. Overwhelmingly in such cases, the methadone has been prescribed in takeaway form by a medical practitioner and has not been used as directed.

Dr Thompson reported that, since the death of another methadone patient in 2022 as well as the death of SH, he has reviewed methadone prescriptions to all other patients – reducing doses to the minimum effective dose possible, reviewing all other medications prescribed, and reducing takeaway doses numbers in an attempt to prevent any further methadone related deaths.

I do not consider that SH deliberately ended her life. I find that, unfortunately, she unintentionally succumbed to the toxic effects of multiple drugs (prescription and non-prescription) and a large quantity of alcohol. Her severe chronic pain, distressed mental state and incapacity were secondary factors in her death.

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

Dated: 11 December 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner