



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Leigh Mackey, Coroner, having investigated the death of UV

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

- a) The identity of the deceased is UV. UV was 33 years of age (date of birth 1 November 1989) when he died. He was the third of six children born to his parents, MF and LO. UV had a difficult childhood with frequent moves, changes in his school and the marital breakdown and separation of his parents. In his teen years he experienced homelessness after his mother and two youngest siblings moved to Victoria and the arrangements made for him to live with his grandmother in Tasmania broke down.

UV had a complex psychiatric history. He had been diagnosed with bipolar affective disorder, autism, attention deficit/hyperactivity disorder, schizoaffective disorder, insomnia, generalised anxiety and social anxiety. Whilst his engagement with psychiatric care had been ad hoc, he came under the care of the Crisis Assessment and Treatment Team (CATT) until discharged by them in January 2022. At that time they noted their focus had been on sleep difficulties which were a risk to precipitating a manic episode. Bipolar disorder was described as being in remission, alcohol use disorder as mild in severity and it was noted that UV had declined intervention with alcohol and drug services.

At the time of his death UV had been under the care of a general practitioner, Dr Onwuegbuzie and was prescribed lithium,¹ mirtazapine,² quetiapine,³ oxazepam⁴ and prodeine.⁵

UV had an addiction to substances through most of his life particularly alcohol, opiates and cannabis. Unsurprisingly, given his mental health and addiction issues,

¹ A mood stabilising medicine used to treat bipolar disorder.

² A tetracyclic antidepressant used to treat depression.

³ An atypical antipsychotic used to treat schizophrenia, bipolar disorder and major depression.

⁴ A benzodiazepine used to treat excessive anxiety.

⁵ An analgesic used for the relief of pain.

he engaged, at times, in antisocial behaviour. He had a criminal record involving matters of civil disobedience from 16 years of age escalating to burglary. His criminal offending, aside from driving matters, appeared to have ceased, from 2012 to 2021, based on his record of convictions. The gap in offending coincided with his relationship with AD⁶ and becoming a father.

UV and AD commenced their relationship in 2012. They had two children, PR (now 12 years old) and GS (now 9 years old). During the relationship UV made efforts to curb his use of addictive substances. UV loved his daughters and being involved in their care and upbringing. His ability to do so became difficult when his relationship with their mother, AD, broke down and protective orders were put in place.

UV and AD initially separated in 2017. UV struggled to accept the end of the relationship. A Police Family Violence Order (PFVO) was made on 24 January 2018 preventing his access to AD. Nevertheless from this time until 2021 the couple returned at times to residing together. UV appeared motivated to work on his addictions and mental health and be more involved with his children. In 2021 the relationship deteriorated, UV's drinking increased and his mental health worsened. The family had financial concerns and argued more. AD moved out with the children. UV reacted poorly. On 12 July 2021 he arrived at AD's home and hit, kicked and strangled her. He was charged with assault and was remanded in custody before being released on bail. A Family Violence Order (FVO) was made preventing his access to AD and the children.

As a result of bail breaches UV was returned to custody in September 2022 where he remained until sentenced in February 2023. From that time he was housed in the medium division of the Risdon Prison Complex until he was released once he had served his sentence.

- b) UV was released from prison on a 7 April 2023. On 8 March 2023 a FVO was made preventing his contact with AD and his daughters except by letter or email contact to discuss matters relating to their relationship and the children. UV returned to his unit. He remained in contact with his mother and she describes him as expressing to her his profound sadness at this time. He was worried about how he would survive and missed his daughters.

⁶ AD and UV never married however AD took UV's surname once they had children together.

UV continued to communicate with AD. They communicated through texts, mainly about their daughters, as required by the FVO. On Monday 17 April 2023, UV and AD exchanged texts from late afternoon until 8pm at which time he wished the children a goodnight and “*everything seemed normal*”.⁷

UV had spent time with a friend, Remi Jacobson-Homes, on 17 April 2023. Remi has refused to assist the investigation into UV’s death other than to say that UV left Remi’s home at 6.59pm on 17 April 2023 to go to his unit and he received a text message from him at 11.05am the following day. As possession of UV’s mobile phone was not taken by attending police officer and its contents were not interrogated, the content of that text messaging remains unknown. Remi’s sister, Georgia, recalls UV saying that he was waiting for ice and morphine as he was feeling down about not seeing his children but had not made any comment suggesting an intention to self-harm or suicide. This accords with his past pattern of reverting to substance abuse at times of relationship stress.

UV was also in text communication with his mother on 18 April 2023. She states that the messages started at 4.06am, which was common as UV had trouble sleeping. The last message she received from UV was at 11.05am.

On 18 April 2023 AD sent a text to UV at 1.44pm and again at 2.47pm. She didn’t get a response. She tried to call him without success. Concerned AD drove to UV’s unit to check on him. On arrival she saw the lights were on in the unit, the door was open and UV was lying on the bed. She called for emergency services to attend and performed cardiopulmonary resuscitation (CPR) until CPR was taken over by paramedics and police upon their arrival at the unit. Efforts at CPR were maintained for over 30 minutes but were unsuccessful.

- c) A postmortem examination of UV was conducted by Dr Ritchey MD. Dr Ritchey concluded that UV died from mixed drug toxicity.⁸ I accept his opinion. Toxicology testing was undertaken on UV’s blood after his death. Whilst some caution needs to be taken when interpreting the concentration of drugs found due to the redistribution effect of death, toxicology tests revealed the presence of several central nervous system depressants in UV’s blood; morphine, diazepam, oxazepam, methadone, mirtazapine and quetiapine, and a central nervous system stimulant, methylamphetamine. Morphine was present in the blood at a high concentration. There was no prescribed source for the morphine, diazepam and

⁷ Affidavit of AD sworn 18 April 2023 p2.

⁸ Short final report of death by Dr Ritchey MD.

methadone. These drugs, together with the methylamphetamine, had been obtained by UV illicitly.

Central nervous system depressants can cause sedation, incoordination, staggering, blurred vision, impaired thinking, slurred speech, impaired perception, slowed reflexes and breathing, decreased heart rate, reduced sensitivity to pain and loss of consciousness possibly leading to coma or death.⁹ The concomitant use of a central nervous stimulant, such as methylamphetamine, does not cancel out the effects of either agent.¹⁰ Other than the presence of prescribed medication, there were no physical signs of illicit drug use found at UV's unit. Where and how he obtained and used the illicit substances remains unknown.

d) UV died on 18 April 2023 at his unit at West Moonah, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of Juliette Tria (Toxicology);
- Medical records of Kingborough Medical Centre, Tasmania Health Service, and Department Health and Human Services;
- Department of Health and Human Services Correctional Services records;
- Email from MF;
- Affidavit of AD;
- Affidavit of Intensive Care Paramedic Alexander Hartley;
- Affidavits of attending Tasmanian Police officers, including scene photographs;
- Body worn camera footage;
- Record of prior convictions of UV;
- Family violence reports; and
- Tasmania Police records.

Was UV's death an intended or unintended consequence of his drug use?

UV had at various times in his life expressed an intent to suicide. On 24 August 2010, he attended the emergency department of the Royal Hobart Hospital and gave a history of

⁹ Affidavit of Juliette Tria sworn 14 July 2023 p2.

¹⁰ Affidavit of Juliette Tria sworn 14 July 2023 p2.

wanting to kill himself by overdosing and feeling that life was not worth living. In a psychiatric assessment undertaken on 18 January 2012 he was described as having “*long standing suicidal ideation*” with low mood for the past year.¹¹ At times, however, UV has mistakenly taken substances to excess without suicidal ideation resulting in significant impairment of function and the need for medical assistance. On 17 May 2009, he attended the emergency department of the Royal Hobart Hospital having overdosed on codeine. He denied any suicidal intent at that time. There are no recent medical records in which he expresses a suicidal intent.

Whether or not UV took the drugs he did with the intention to cause his own death will not be known with certainty. There are matters that were causing him upset at the time of his death. A “*brief*” view of his computer search history by an attending Detective Senior Constable revealed that on the morning of 18 April 2023 UV searched “*bankruptcy wipe debt*” and “*NDIS payment not clearing*” suggesting he had financial concerns.¹² He was struggling with the separation from his daughters. His mother describes him as expressing sadness in her text messages communication with him over 17 to 18 April 2023. However, there were demonstrations of UV’s future focus at this time. Receipts at his unit showed he had purchased an air fryer, induction cooker and microwave on 17 April 2023, and when reviewed at Risdon Prison Complex on 14 March 2023 he expressed post release plans of spending time in Queensland with his mother, visiting a friend in Perth to drink and play cards, getting a new car and considering working.¹³ He expressed confidence in not taking illicit substances and requested a handover of his records to his community general practitioner. There was no evidence of UV having made any preparation for his death including by writing to others.

The investigation

UV’s death was investigated by Tasmania Police. Uniformed members of the Glenorchy Branch of Tasmania Police and CIB attended UV’s home. Whilst UV’s front door was open, there was no signs of disturbance nor anything that would suggest the involvement of a third party in his death. UV had not suffered any traumatic injury and other items of value remained in the home. The conclusion that UV’s death had been the result of his own action, without the involvement of another, was reasonably made. However, the investigation of his death called for more. To gain an understanding of UV’s use of prescribed and unprescribed substances further investigation was warranted. Forensically interrogating UV’s mobile phone and computer search history, actively seeking information from person or persons who had been with him shortly prior to his death as to his state of mind and pattern of drug use, and others who could provide an understanding as to the extent of and source of his illicit drug use after

¹¹ Department of Health and Human Services Mental Health Services records.

¹² Tasmania Police Incident report.

¹³ Department of Health and Human Services Correctional Services records.

leaving Risdon Prison and his mental health, were pertinent steps to the investigation but were not undertaken. Some aspects of the investigation that were important were undertaken in an ad hoc way including speaking to Remi Jacobson-Homes and his sister and considering UV's computer search history. Whilst the cause of UV's death is clear, these omissions have hindered the gaining of an understanding of all the circumstances relevant to his death.

Comments and Recommendations

A draft form of this finding was made available to Tasmania Police to provide an opportunity for them to respond to the issues raised regarding the standard of investigation into UV's death. Responding on behalf of Tasmania Police, Assistant Commissioner, Operations, A P Bodnar, confirmed the significant importance placed by Tasmania Police on conducting a thorough investigation of sudden deaths in this State. When a sudden death is suspected to involve the use of drugs, specific procedures are outlined in the Tasmania Police Manual to ensure appropriate oversight by Drugs and Firearms Services and attendance by either drug investigators or members of the Criminal Investigation Branch (CIB) at the scene in the first instance. It is noted that whilst members of CIB did attend the scene of UV's death they had no ongoing involvement in the investigation.

Tasmania Police recruits, as part of their academy training, are provided education specifically relating to their attendance at the scene of suicides including drug overdoses, the seizure and handling of exhibits, the required attendance by Drug and Firearm Services or CIB and Forensic Services personnel at such scenes and their reporting, file preparation and file completion requirements.

The circumstances of death relating to drug use requires a thorough investigation to assist in gaining an understanding wherever possible as to the source of the drugs used, how they were used and why they were used. This information can be valuable to inform coronial findings and recommendations directed toward the prevention of future deaths. The minimum standard of investigation calls for police officers attending the scene of a death apparently involving drug toxicity to have received education and instruction regarding the following matters:

- a. The importance in coronial investigations of seizing and categorising medication, drugs or substances located at the scene;
- b. The importance in coronial investigations of seizing and interrogating electronic devices located at the scene; and

- c. The importance of obtaining a detailed statement/affidavit from witnesses at the earliest possible opportunity to assist the coroner to determine the circumstances of death.

I am advised by Tasmania Police that this education forms part of the training of police recruits and is in part captured by the Tasmania Police Manual, they have and, following the provision of these findings to them in draft form, Assistant Commissioner, Operations, A P Bodnar has acted by writing to the Commander of each of the Tasmanian districts; Southern, Northern and Western, requesting that these requirements for investigation into such deaths as set out in the Tasmania Police Manual be reinforced with all members and appropriate support be given to those members undertaking such investigations to ensure they are completed to a high standard.

In light of Tasmania Police's response, I consider that it is not necessary for me to make any formal recommendations pursuant to Section 28 of the *Coroners Act 1995*.

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

Dated: 1 August 2025 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner