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 Trent Ian Johnston

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

a) The identity of the deceased is Trent Ian Johnston;

b) Mr Johnston died in circumstances set out below;

c) Mr Johnston's cause of death was aspiration pneumonitis, with acute alcoholic hepatitis and pancreatitis, mixed drug toxicity (codeine, morphine, diazepam and paracetamol) and emphysema; and

d) Mr Johnston died on 9 November 2021 at the North West Regional Hospital, Burnie, Tasmania.

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

- Tasmania Police Report of Death for the Coroner and subject report;
- Tasmanian Health Service Death Report to the Coroner;
- Opinion of the pathologist Dr Donald Ritchey;
- Toxicology report, Neil McLachlan-Troup;
- Affidavit of Glen Johnston;
- Affidavit of Donna Beswick;
- Affidavit of Constable Andrew Wood;
- Records of North West Regional Hospital; and
- Records of City Medical Practice.

The circumstances of Mr Johnston's death

Mr Johnston was 40 years of age at the time of his death. He was born on 20 June 1981 and was the youngest of four children to his parents, Lavern and Carol. Mr Johnston lived in the Northwest region of Tasmania, he never married and was unemployed. At a psychiatric

assessment in 2017 he described his parents as having been "warm and loving".[1] However for much of his adult life Mr Johnston was itinerant and reclusive. He lived for significant periods in the open, in a tent or in shelters. At the time of his death he was living with a family friend, Donna Beswick. She describes him at that time as keeping to himself, having no visitors and rarely leaving her address.

Mr Johnston lived a lifestyle that was counterproductive to his health. He drank alcohol to excess, abused illicit substances, was inactive and lived rough. At times over his life, he sought medical care for drug induced hallucinations, cellulitis and musculoskeletal pain and had been diagnosed with chronic paranoid schizophrenia.

On the days prior to his death Mr Johnston complained of abdominal pain but refused the suggestion that he seek medical attention. On 9 November 2021 he was driven by Ms Beswick to the Wynyard supermarket. Mr Johnston remained in the vehicle whilst Ms Beswick left him to shop. During this period Ms Beswick twice returned to the vehicle to check on the shopping needs with Mr Johnston. On both those occasions there was, on her assessment, nothing amiss. When she again returned, approximately half an hour after they had first arrived at the shopping centre, she found Mr Johnston slumped in his seat with blood coming from his nose and to her he "looked dead". Ms Beswick drove Mr Johnston to the local General Practice, Wynyard Medical Centre, where cardiopulmonary resuscitation (CPR) was commenced and an ambulance called. On arrival Ambulance Tasmania (AT) personnel noted Mr Johnston to be unconscious and receiving CPR, he was very pale and cold to the touch. He had obvious dried coffee ground vomitus over his face and forehead and had obvious marks to both arms consistent with intravenous drug use.

Mr Johnston was taken by AT to the Northwest Regional Hospital (NWRH). On arrival in the Emergency Department, he had a Glasgow Coma Scale score of 3 and was hypotensive with severe acidosis and high lactate levels. Life saving measures were undertaken including intravenous fluid therapy and intubation. Mr Johnston was transferred into the Intensive Care Unit (ICU) and despite the best efforts of the medical team and the cardiopulmonary support given his organs commenced to fail.

Having been alerted to his condition Mr Johnston's father and brother attended the NWRH. It was considered that his deteriorating condition was not survivable and after discussions between the medical team and family life support was withdrawn. Mr Johnston died at 7.00 pm on 9 November 2021.

[1] NWRH records consultation Dr Butt 23 June 2017.

An autopsy was conducted by Dr Donald Ritchey, forensic pathologist. Dr Ritchey observed Mr Johnston to be thin and chronically ill in appearance with multiple recent and chronic needle track injuries of the bilateral cubital fossa and forearms. He had advanced disease of his lungs caused by smoking and a large quantity of dark vomit in his trachea and lower airways. Microbiology confirmed aspiration and inflammation. Consistent with his history of drug and alcohol abuse Mr Johnston had acute hepatitis and necrotising pancreatitis. Toxicology results demonstrated markedly elevated levels of codeine, morphine and paracetamol. The levels of codeine and morphine, both central nervous system depressants, were within a fatal range. Tetrahydrocannabinol (THC) was also present. I accept Dr Ritchey's observations and opinions and noting the toxicology results, find that Mr Johnston died due to aspiration pneumonitis (the inhalation of stomach or mouth contents into the lungs) on the background of mixed drug toxicity.

Comments and Recommendations

The circumstances of Mr Johnston'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 convey my sincere condolences to the family and loved ones of Mr Johnston.

Dated: 10 June 2025 at Hobart Coroners Court in the State of Tasmania.

Leigh Mackey
Coroner