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**FINDINGS, COMMENTS and RECOMMENDATIONS  
of Coroner Olivia McTaggart following the holding  
of an inquest under the *Coroners Act 1995* into the  
deaths of:**

**Nicholas Shane Brown, Toni Lee Wiki, Matthew  
Wayne Winwood and Belinda Emma Kemp**

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# Record of Investigation into Death (With Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Olivia McTaggart, Coroner, having investigated the deaths of Nicholas Shane Brown, Toni Lee Wiki, Matthew Wayne Winwood and Belinda Emma Kemp, with an inquest held at Hobart in Tasmania, make the following findings:

## Hearing Dates

12-16, 19-21, 23, 26-30 September, 3 October, 25 November 2022 and 23-26, 30-31 May, 22 June, 12-13 September 2023, 12 October 2023 and 5 August 2024.

Closing submissions and submissions in reply received by 12 May 2025.

## Representation

Counsel Assisting the Coroner: L Fox and E Bill

Counsel for Pharmacists (Marjorie Cook, Stephen Ives, Michael Nash, Jerry Hampton and Wendy Steinberg): R Walsh and E Arms

Counsel for Salvation Army and Nikolaas Azon-Jacometti: A Mills

Counsel for Mr David Jackson: C Law

## Introduction

1. The deaths of the four persons, the subject of this inquest, occurred over an 11 month period between 2016 and 2017. They are Nicholas Shane Brown, aged 35 years, Toni Lee Wiki, aged 38 years, Matthew Wayne Winwood, aged 47 years, and Belinda Emma Kemp, aged 37 years.
2. The four deaths jointly were the subject of a very lengthy investigation, culminating in my formal determination under section 50 of the *Coroners Act* 1995 ("the Act") to hold a joint inquest. This was because there were a number of factual similarities between the circumstances of death, potential cause of death and the evidence relating to each of the deaths. Specifically:
  - a) Each of the deceased were drug dependent and, at the time of death, each were prescribed methadone as part of opioid replacement therapy ("ORT") by Dr David Jackson.

- b) Each of the deceased were, at the time of death, also prescribed benzodiazepines by Dr Jackson.
  - c) The forensic pathologist identified the primary cause of death for each of Mr Brown, Ms Wiki and Mr Winwood as combined drug intoxication, those drugs being, inter alia, methadone and benzodiazepine(s). In the case of Ms Kemp, the forensic pathologist concluded that the primary cause of death was aspiration pneumonia but that was due to mixed prescription drug toxicity, including by methadone and benzodiazepines.
  - d) In the case of Mr Brown and Ms Wiki, there appeared evidence that they both intravenously used methadone or another substance prior to death.
  - e) There was evidence in the investigation that Dr Jackson's supply of prescribed takeaway doses of methadone was contrary to the governing guidelines and that his excess supply of methadone to each deceased may have contributed to their death.
3. The *Tasmanian Opioid Pharmacotherapy Program Policy and Clinical Practice Standards 2012* (hereinafter called "TOPP") were Tasmanian guidelines in existence at the time of the deaths. The guidelines aimed to set standards for medical practitioners and pharmacists regarding how to safely prescribe and manage patients on ORT. Much of the evidence referred to whether each of the four deceased were prescribed in accordance with the TOPP.
4. In the simplest of terms, ORT or, relevantly, "the methadone program"<sup>1</sup> aims to stop a patient's illegal and harmful opioid drug addiction, and the risks associated with that, and thus to improve the patient's health and daily functioning.<sup>2</sup> The program involves the patient taking a controlled daily dose of methadone under supervision at a clinic or pharmacy. As methadone is a long-acting medication that acts on the same area of the brain as opioids, it is designed to stop withdrawal and cravings. The patient's program is managed by a medical practitioner, with an initial assessment and ongoing assessments of stability. Once stable, the medical practitioner may allow the patient to take home doses instead of attending daily. Other services, including counselling and mental health support, are, ideally an integral part of the program. A patient's dose of methadone may gradually be reduced. However, other patients remain on methadone indefinitely.

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1 As it was widely referred to at inquest-for example T49, T1967, T2358.

2 See TOPP guidelines.

5. An independent expert opinion was sought and obtained in the investigation from Dr Jonathan Brett, a consultant in clinical toxicology, clinical pharmacology and addiction medicine in New South Wales. Dr Brett is a highly qualified and experienced specialist, whose expertise was wholly applicable to the issues considered in this inquest. His expertise in addiction medicine was not challenged.
6. Dr Brett is an Associate Professor with St Vincent's Clinical School, University of New South Wales. His clinical work involves care of people with complex medication related issues, addictions and poisonings at St Vincent's Hospital in Sydney. He is the Clinical Director of the Psychiatry and Drug and Alcohol Unit at St Vincent's Hospital, caring for people with intoxication, poisonings, mental health and associated social issues. In relation to opioid replacement therapy (ORT), he was the Clinical Director of the opioid substitution clinic at St Vincent's Hospital between 2019 and 2021. He was a former member of the New South Wales Ministry of Health Review Committee of the New South Wales opioid substitution therapy program. He is the National Coordinator of Advanced Training in Addiction Medicine with the Royal Australasian College of Physicians. Dr Brett completed PhD in medicines policy related to psychotropic prescribing, and he has a research interest in prescription drug misuse. He has significant experience in providing independent opinions in the legal context as an expert witness.<sup>3</sup>
7. Dr Brett provided comprehensive expert evidence in the investigation, comprising three written reports and sworn oral evidence at inquest on two occasions.<sup>4</sup>
8. Dr Brett provided general evidence regarding the practice of opioid pharmacotherapy, as well as a detailed analysis of his opinion regarding the practices of Dr Jackson in his treatment of each of the deceased.
9. In relation to the four deceased, Dr Brett stated that, contrary to proper practice, Dr Jackson;
  - a. Prescribed excessive take away doses despite lack of clinical stability contrary to the TOPP;

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3 G1B pages 1 and 2.

4 Reports dated 11 May 2018, 14 July 2022 and 26 May 2023 – exhibits G1A-C. He also gave evidence at the inquest on 21 September 2022 - T1003 to 1115 and on 13 September 2023- T 2712 to 2770.

- b. Prescribed ORT without authority from Pharmaceutical Services Branch,<sup>5</sup> contrary to governing legislation;<sup>6</sup>
  - c. Prescribed high dose benzodiazepines and other sedative prescribing without controlled dispensing and in the absence of a plan to taper/wean doses, contrary to TOPP and best practice;
  - d. Lacked due diligence in confirming patient histories and last dose details of ORT when taking over prescribing of ORT from other providers;
  - e. Failed to perform adequate clinical reviews and formulate management plans contrary to best practice. Along with poor clinical judgement, this led to a failure to appreciate the severity of addiction or extent of stability in patients for whom Dr Jackson was prescribing ORT;
  - f. Was overly reliant on patient assessments performed by a registered nurse when making critical treatment decisions regarding ORT prescriptions;
  - g. A lack of urine drug monitoring contrary to the TOPP; and
  - h. All of these omissions in care led to a failure to identify the risks of overdose and death associated with his prescribing.<sup>7</sup>
10. Dr Brett stated in evidence that he did not consider Dr Jackson provided safe care in managing their ORT.<sup>8</sup>
11. This investigation, as it evolved from the beginning, became an intensive, lengthy and large scale criminal investigation with a team of highly experienced detectives. Further evidence was obtained which led the criminal investigators to form the view that Dr Jackson's actions were grossly negligent and that homicide charges, namely manslaughter, should be considered by the Director of Public Prosecutions ("DPP").
12. The criminal investigation proceeded on the basis that Dr Jackson owed a duty of care to each of the deceased, that he displayed a high degree of negligence in performing that duty, and, that the negligence accelerated and caused their deaths. This was for the following reasons:

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<sup>5</sup> Part of the Department of Health.

<sup>6</sup> *Poisons Act 1971*.

<sup>7</sup> G1B.

<sup>8</sup> Transcript Dr Jonathan Brett at Inquest, p.1036.

1. Dr Jackson displayed a high degree of negligence in his lack of clinical examinations of Mr Brown, Ms Wiki, Mr Winwood and Ms Kemp;
  2. Dr Jackson displayed a high degree of negligence in his over prescription of takeaway doses. (Also referred to as TADs);
  3. Dr Jackson displayed a high degree of negligence in his co-prescription of methadone and benzodiazepines to Mr Brown, Ms Wiki, Ms Kemp and Mr Winwood;
  4. Dr Jackson displayed a high degree of negligence by disregarding safe methadone prescribing practices toward Mr Brown, Ms Wiki, Ms Kemp and Mr Winwood;
  5. Some of his actions and statements following the deaths indicated a consciousness of guilt on the basis that he did not comply with the Coroner's request to supply his patient records for Mr Brown, Ms Kemp and Mr Winwood;
  6. Dr Jackson's negligent conduct was not limited to the four deceased, and in fact he displayed the same high degree of negligence toward his other patients on ORT; and
  7. Dr Jackson was negligent in his lack of reflective practices following the individual deaths.
13. The criminal investigation also focused on 13 living patients, to whom it was alleged that Dr Jackson also prescribed contrary to proper standards. The investigation team intended that such evidence was to fall into the category of corroborative tendency evidence.
14. On 10 June 2021, the DPP, in correspondence to the investigators, determined that the evidence could not sustain convictions for manslaughter against any of the deceased, even if Dr Jackson's prescribing was dangerous or negligent or contrary to appropriate clinical guidelines. On that basis, the DPP therefore declined to charge him. It is inappropriate for me to comment upon the decision of the DPP, other than to provide this summary for an understanding of the trajectory of this matter towards inquest.
15. Following the DPP's decision not to charge Dr Jackson with manslaughter or any other offences, the focus of the investigation turned to preparation for the coronial inquest. For this purpose, Dr Brett was asked to prepare a second

expert report. In his second report, Dr Brett stated that he adhered to his original opinions and expanded upon his reasons for doing so.<sup>9</sup>

16. Given the volume of the evidence, summaries based upon the reports of each investigating officer were prepared and relied upon by Dr Brett for the purpose of forming his opinions. The summaries were lengthy, detailed and referenced the original documentary exhibits. No issue was ultimately taken by any counsel as to the accuracy of the facts contained in these summaries. Further, no closing submissions were made by any counsel that Dr Brett's opinion as an expert was based upon facts that were not established in evidence. In any event, I am satisfied that on the critical matters of Dr Brett's opinion, he was in receipt of comprehensive and accurate facts.
17. Sadly, the originally appointed counsel assisting, Ms Allison Shand, died suddenly in November 2020. In October 2021, Ms Bill was appointed as counsel assisting. In August 2022, Ms Fox was also appointed in August 2022 as counsel assisting with Ms Bill.
18. The scope and interested parties were then identified and a series of case management conferences were held in Court, whereby the scope of inquest was settled following various applications and submissions by counsel for interested parties.<sup>10</sup>

### **Role of the coroner**

19. The functions of a coroner are prescribed by the *Coroners Act 1995* ("the Act"). Under the Act, a coroner has jurisdiction to investigate any death that occurs in Tasmania and appears to "*have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury*".<sup>11</sup> The reported deaths of the four deceased appeared to be unexpected or resulted from accidental methadone toxicity. Thus, they fell within the jurisdiction of the coroner.
20. The coroner's role under the Act in investigating any reportable death is inquisitorial. A coroner must investigate the death and determine the matters required by section 28(1) of the Act. Those matters include the identity of the

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<sup>9</sup> G1B Report of Dr Brett dated 14 July 2022.

<sup>10</sup> CMC1 16 June 2022, CMC2 23 and 26 August 2022, 12 and 13 September 2022.

<sup>11</sup> Section 3 – definition of "*reportable death*".

deceased, how the deceased died, the cause of death and where and when the person died.

21. This process requires a coroner to make these findings without apportioning legal or moral blame for the death.<sup>12</sup> The coroner is to make findings of fact about the death from which others may draw conclusions. A coroner does not charge people with criminal offences or punish or award compensation to anyone, as such functions are for other courts. A coroner conducting an inquest holds an inquiry into a death with the benefit of oral testimony and documentary evidence to make the required findings.

#### Recommendations and comments

22. Importantly, the role of the coroner is also critical in identifying matters contributing to or connected with any individual death with a view to making comments and recommendations for the prevention of further deaths. The Act sets out in section 28 these important functions as follows:

*“(2)A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.*

*(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.”*

23. Throughout the years, coronial recommendations have been instrumental in many changes and developments creating a safer community. A coroner, pursuant to the powers under the Act, may make comments and recommendations about matters which have sufficient nexus to a death, even though the matter the subject of the comment or recommendation cannot be necessarily found to be a matter which would, if it had been present, have averted death.<sup>13</sup>

#### Standard of proof for findings

24. The standard of proof at an inquest is the civil standard. Therefore, where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, where findings may

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<sup>12</sup> *R v Tennent; Ex Parte Jager* [2000] TASSC 64.

<sup>13</sup> See, for example, *Doomadgee & Anor v Deputy State Coroner Clements & Ors* [2005] QSC; *Commissioner of Police NSW Police Force v Attorney General of NSW* [2025] NSWSC 1119 357; *Hurley v Deputy State Coroner Clements & Ors* [2005] QSC 357 paragraphs [26] to [33].

reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.<sup>14</sup>

#### Not bound by rules of evidence

25. The coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.<sup>15</sup> To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation. The coroner has significant latitude in receiving evidence, providing the material is something more than “*mere supposition, guess or intuitive hypothesis*”.<sup>16</sup> The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

#### Principles governing scope

26. In setting the scope, admitting evidence and conducting an inquest generally, a coroner must bear steadily in mind his or her duty to discharge the obligation imposed by section 28(1)(b) of the Act, being to make findings as to how death occurred. ‘*How*’ has been determined to mean ‘*by what means and in what circumstances*’,<sup>17</sup> a phrase involving the application of the ordinary concepts of legal causation.<sup>18</sup> Any coronial inquest necessarily involves a consideration of the circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.
27. In *Conway v Jerram*, the members of the New South Wales Court of Appeal observed that the scope of an inquest is a matter for the coroner to determine using both proper discretion and common sense.<sup>19</sup> Campbell JA referred to *Harmsworth v State Coroner* in which Nathan J discussed the fact that the enquiry must be relevant in the legal sense to the death and that a coroner is

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14 (1938) 60 CLR 336 (see in particular Dixon J at page 362).

15 Section 51 of the Act.

16 See *Ruling and reasons* of Coroner Cooper in the *Inquest into the deaths of Craig Nigel Gleeson, Alistair Michael Lucas and Michael George Welsh* dated 1 February 2018, and the authorities referred to therein.

17 See *Atkinson v Morrow* [2005] QCA 353.

18 See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.

19 [2011] NSWCA 319 at [47]-[48].

not permitted to conduct a “*wide, prolix and indeterminate*” inquest surrounding remote issues.<sup>20</sup>

28. The judgments of *Re State Coroner; Ex parte Minister for Health*<sup>21</sup> and *R v Doogan; Ex parte Lucas-Smith*<sup>22</sup> also emphasise that the coroner is not authorised within his or her proper limits to undertake a roving enquiry into any possible causal connection, no matter how tenuous, between a particular fact or circumstance and the death of the deceased.
29. The coroner’s function of finding *how death occurred* usually requires the coroner to make an assessment for the purposes of the scope of the inquiry as to the substantial or operating causes of the death. These causes should not be merely part of the background or too remote. The question of causation should be determined by applying common sense to the facts and not resolved by speculative or hypothetical theories.<sup>23</sup>
30. In *Re the State Coroner; Ex Parte the Minister for Health*, Buss JA stated:<sup>24</sup>

*“...In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation...Also, this construction is consistent with the decision of the Court of Appeal of Queensland in Atkinson on a comparable statutory provision...”*

*44. The coroner, in finding, if possible ‘the cause of death’, is not confined or restricted by concepts such as ‘direct cause’, ‘direct manner’, ‘direct and natural cause’, ‘proximate cause’ or the ‘real or effective cause’. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable...*

*47. It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of death of the deceased. This is to*

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<sup>20</sup> *Harmsworth v State Coroner* [1989] VR 989.

<sup>21</sup> [2009] WASCA 165.

<sup>22</sup> [2005] ACTSC 74.

<sup>23</sup> See for example: *E & MH March v Stramare Pty Ltd* (1991) 171 CLR 506; *Campbell v The Queen* (1981) WAR 286; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; and *Atkinson v Morrow and Anor* [2005] QCA 353.

<sup>24</sup> At [42].

*be undertaken by applying ordinary common sense and experience to the facts of the particular case.”*

31. Additionally, the wide powers given to a coroner under s28(2) to make recommendations “with respect to ways of preventing further deaths” also support a broad construction of powers to make findings under s28(1) as to “*how death occurred*” and the “*cause of death*” within the parameters of the authorities, such as those cited above.

### **Scope**

32. The scope of the inquest was as follows:
  1. The matters required for finding under section 28(1) (a)-(d) of *the Coroners Act 1995*, and, specifically in relation to cause of death, the contribution of methadone and other drugs to the death of each of the deceased;
  2. Consideration of TOPP guidelines, legislation and policies in place at the time of the deaths, and currently, as connected to one or more of the deaths;
  3. The role of those involved in the administration of opioid pharmacotherapy or prescription of methadone and other medications to each of the deceased as connected to the death, including prescribing doctors, nurses and dispensing pharmacists, with reference to the TOPP and relevant legislation and requirements for such administration.
  4. Consideration of the role or functions of Pharmaceutical Services Branch (“PSB”) and Alcohol and Drug Service in the opioid pharmacotherapy program, as connected to one or more of the deaths; and
  5. The contribution, if any, of those involved in the administration of pharmacotherapy, prescription of methadone and other medications to the cause of death of any of the deceased.

## Explanatory terms and concepts

### Poisons Act 1971

33. The *Poisons Act* 1971 is Tasmanian legislation governing the regulation, control and prohibition of the importation, making, refining, preparation, sale, supply, use, possession, and prescription of certain substances and plants.
34. Section 59 covers the regulation of narcotics and narcotic substances. Of significance, if a patient has previously been declared drug dependent by a medical practitioner under section 59B of the *Poisons Act*, an authority is required from a delegate of the Secretary of Health. Section 59C of the *Poisons Act* states it is an offence to make available a narcotic substance to a drug dependant person without the required authority.
35. Section 59E of the *Poisons Act* requires an authority to be issued before a patient can be prescribed any opioid pharmacotherapy treatment for opioid substance use disorder (addiction). Such opioid pharmacotherapy treatments include methadone and buprenorphine (suboxone and Subutex). The records of all section 59E authorities to prescribe narcotic substances, are issued to prescribers by PSB.
36. PSB is a division within the Tasmanian Government Department of Health and is responsible for administering the *Poisons Act* and subordinate *Poisons Regulations 2018*, in Tasmania. Records relating to the supply to patients of all Schedule 8 substances (including methadone, buprenorphine and oxycodone) are sent to PSB by Tasmanian pharmacies. These records show who received and who prescribed these substances, including where and when they were dispensed.
37. To obtain an authority under section 59E of the *Poisons Act*, an application must be completed by the accredited prescriber and forwarded to PSB for consideration and assessment. An authority may then be granted by a delegate (Pharmacist at PSB) of the Secretary stipulating the conditions in which the Schedule 8 drug can be prescribed by the medical practitioner. It is only then that the medical practitioner may commence prescribing the narcotic substance. A prescriber of methadone and buprenorphine, as Schedule 8 substances, must be authorised. It is an offence for a prescriber to supply those substances (or other Schedule 8 drug) without an authority.<sup>25</sup>

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25 Section 59C (1) of the *Poisons Act* 1971.

Tasmanian Opioid Pharmacotherapy Program Policy and Clinical Practice Standards 2012 (TOPP)

38. The TOPP<sup>26</sup> is a comprehensive 263-page document designed to guide medical practitioners, pharmacists, nurses and allied health professionals in the safe delivery of opioid pharmacotherapy. The TOPP superseded the previous policy, The *Tasmanian Methadone Policy 2000*, which was prepared by the Alcohol and Drug Service and was based upon the *National Policy on Methadone Treatment* (1997). This policy updated the guidelines and requirements for the operation of the methadone program in Tasmania and superseded the earlier *Tasmanian Methadone Program Policy* (1996).
39. Like the *Tasmanian Methadone Policy 2000*, the TOPP identified that methadone maintenance treatment was recognised nationally and internationally as an effective method for treating opioid dependence, as well as reducing the individual and social harms associated with illegal opioid use.
40. The TOPP provides that, '*Alcohol and Drug Services and private practitioners offering opioid pharmacotherapy should provide this treatment in a manner consistent with the Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards (2012).*'
41. The TOPP '*... provides the policy framework and clinical practice standards for the treatment of opioid dependence in Tasmania.*' It delivers guidelines for the treatment of opioid dependence with methadone and buprenorphine. It was '*... developed based on contemporary evidence and national and jurisdictional clinical policies and guidelines for the use of methadone, buprenorphine and naltrexone in the treatment of opioid dependence.*'
42. In the development of the TOPP, consideration was given to the legislative, regulatory and administrative requirements involved in the treatment of opioid dependence. The opioid pharmacotherapy treatment program is described in the TOPP as '*... effective in reducing drug use and the physical, emotional and social harms associated with opioid dependence use.*'
43. Of importance, the TOPP governs the many aspects of ensuring the safety of patients. These include, but are not limited to, the initial entry into opioid pharmacotherapy, safe treatment, induction and maintenance treatment.

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26 [TOPP Policy Clinical Practice Standards DoHTasmania2012.pdf](#).

Patient reviews, urine drug screening, as well as limiting takeaway doses (TADs) are specified as crucial to ensuring the success of the program.

44. Relevant to this inquest, the TOPP cautions about the co-prescription, or co-consumption, of benzodiazepines while on pharmacotherapy including the risks associated as a central nervous system depressant.<sup>27</sup>
45. The TOPP guidelines state, relevantly for this inquest, that a patient must be clinically stable for three months before being prescribed takeaway doses under the program. Section 8.6.3 of the TOPP identifies clinical stability as where the patient has achieved all of the following clinical outcomes:
  - No signs of injecting drug use, including no fresh or recent needle marks;
  - No presentations of intoxication with alcohol or any other drugs to the clinic or pharmacy;
  - Few (1-2 per month), if any, unexplained missed doses;
  - Few (1-2 per month), if any, unexplained missed appointments;
  - Adherence to the treatment agreement;
  - No traces of polysubstance use or unsanctioned opioid use in random supervised urine samples; and
  - Compliance with supervised dosing requirements.
46. While the patient may have met the criteria for clinical stability, the doctor must also be satisfied that ongoing safety is likely to be maintained, which means that:
  - The patient is not using more than 5mg of diazepam, or equivalent per day;
  - The patient does not present with a risk of overdose, injecting drug use, or drug diversion; and
  - The patient is able to safely store the takeaway dose. This also means that patients should be in stable living or housing arrangements.

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<sup>27</sup> G29 8.6.2.

47. One of the overriding principles of the TOPP is that the administration of ORT is something that should be done cooperatively with those involved, including doctors, pharmacists, case managers, nurses and any other providers. These personnel work together in relation to initial and ongoing assessments, particularly in relation to patient stability. Communication between those involved is essential to ensure patient safety and that the patient is getting the most benefit possible from the program.
48. The TOPP was due for review in 2017, although, as at the hearing of the inquest, that review has not been completed.
49. As noted above, the degree to which the TOPP represented appropriate guidelines for ORT managed by private general practitioners and non-ADS health professionals was an issue of contention at inquest.
50. For reasons which I will further discuss, I find that they represented the standard to be adhered to by all medical practitioners in respect of opioid pharmacotherapy in this state.

#### Methadone

51. Methadone is an analgesic and central nervous system (CNS) depressant with similar pharmacological properties to morphine. Potential effects related to the use of methadone include analgesia, drowsiness, weakness, disorientation, sedation, light-headedness, visual disturbances, respiratory depression, hypothermia, euphoria, meiosis (pinpoint pupils), decreased gastrointestinal motility (leading to constipation), nausea and vomiting, and urinary retention. Use of methadone may prolong the QT interval.<sup>28</sup> It is prescribed for the relief of pain and in the treatment of dependence on opioid drugs.
52. In the treatment of opioid dependence, methadone replaces the abused drug (for example, morphine or heroin) to prevent the development of withdrawal symptoms. After an appropriate period of maintenance, methadone itself may be gradually withdrawn. With repeated use of the drug (for example, through participation in a medically supervised program of pain relief or withdrawal from opioid dependence) individuals will become tolerant to the adverse effects associated with methadone.

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<sup>28</sup> The time take for the lower chamber of the heart to electrically squeeze and re-charge.

53. The literature and expert evidence indicates that the primary mechanism responsible for methadone overdose deaths is respiratory depression. In combination with other CNS depressants (for example, mirtazapine, pregabalin, diazepam, melatonin) the respiratory depressant effects of methadone will be enhanced. It has been recognised that many cases of methadone induced death are not attributable to methadone alone but to the combined effects of methadone and another drug or drugs.<sup>29</sup>
54. Suboxone and Subutex are also opioid-based medications referred to in this finding. Like methadone, both are used in the treatment of opioid dependence. Both contain buprenorphine, a partial opioid agonist that reduces cravings and withdrawal symptoms. Suboxone additionally contains naloxone, which is included to deter misuse. These medications are safer for use in ORT in terms of overdose. However, they may nevertheless produce CNS depressant effects and, particularly when used in combination with other CNS depressants, may contribute to sedation and respiratory compromise.

#### Benzodiazepines

55. Benzodiazepines are a class of prescription-only pharmaceutical drugs which act as CNS depressants. Their primary mechanism of action is to enhance the effect of gamma-aminobutyric acid (GABA), a neurotransmitter that inhibits neuronal activity, and therefore producing a calming effect upon the brain.
56. Benzodiazepines are commonly prescribed for the management of anxiety, insomnia, agitation, and, in some circumstances, seizure disorders. In this finding, diazepam (brand name Valium) is the most commonly referred to benzodiazepine. Other benzodiazepines referred to in the evidence are alprazolam (brand name Xanax), temazepam and oxazepam.
57. The pharmacological effects of benzodiazepines include sedation, reduction in anxiety, muscle relaxation, and anticonvulsant activity. An individual under the influence of a benzodiazepine may experience slowed reaction times, impaired judgment, and decreased capacity to respond to external stimuli. Of particular significance in this finding, benzodiazepines may depress respiratory function, especially when taken in higher doses or in combination with other central nervous system depressants, including alcohol or opioid medications. In such

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<sup>29</sup> This passage follows the description in the affidavit of forensic scientist, Miriam Connor CBK6.

circumstances, the risk of profound sedation, loss of consciousness, and death is materially increased.

58. Because of the risks, benzodiazepines are intended for short-term use only. In the context of anxiety or insomnia, prescribing is ordinarily limited to a period of no more than two to four weeks. Prolonged prescribing beyond this period is generally regarded as carrying an increased risk of harm, including dependency.

#### Central nervous system (CNS) depression

59. CNS depression refers to the physiological depression of the central nervous system that can result in a spectrum of symptoms which may potentially 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.<sup>30</sup>
60. The main substances referred to in this finding in the category of CNS depressants include methadone, benzodiazepines, mirtazapine (an antidepressant), pregabalin (for neuropathic pain), olanzapine (an antipsychotic) and alcohol. As will be discussed at length, the concurrent ingestion of two or more CNS depressants substances markedly increases the risk of profound sedation, respiratory depression and death.

#### Alcohol and Drug Services

61. The Tasmanian Alcohol and Drug Services, (ADS), is a state government service operating within the Department of Health and Human Services. ADS is the primary provider of specialist services for Tasmanians who are affected by alcohol, tobacco and other drugs. The service aims to ensure that people that are affected by alcohol, tobacco and other drug use have, as described by former Clinical Director Dr Adrian Reynolds '*access to appropriate, timely, effective and quality treatment services, supports and interventions that are based on contemporary "best practice" standards.*'<sup>31</sup>
62. The ADS provides direct care and case management to patients who are opioid dependent in the form of opioid pharmacotherapy (methadone and

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30 CBK6.

31 G29 page 29: TOPP Foreword.

buprenorphine), in all three regions of Tasmania, operating out of various premises, including the St Johns Park campus in New Town. The Clinical Director has no legal authority or responsibility in relation to private medical practitioners delivering ORT to patients, although the Director and staff of the ADS generally provide guidance to medical practitioners in clinical matters related to alcohol, tobacco and other drug problems.

63. The Clinical Director of ADS is engaged in a wide range of public policy matters relating to alcohol and other drugs as well as clinical service delivery throughout the state. That role is, in part, required to provide clinical leadership to the Statewide Pharmacotherapy Program and Detoxification Unit. Dr Reynolds, whilst holding this role, was responsible for authoring the TOPP.
64. Dr Reynolds commenced as Director of ADS on 13 February 2007. He stepped down from that position after electing not to reapply for a newly created position of Statewide Specialty Director, to which Dr Nicolle Ait Khelifa was appointed.<sup>32</sup> Dr Reynolds and Dr Ait Khelifa, both highly qualified specialists, gave helpful and informative evidence at inquest.

#### Australian Health Practitioner Regulation Agency (“AHPRA”)

65. AHPRA is established by the Health Practitioner Regulation National Law and is the regulatory body relating to, inter alia, medical practitioners. Its main statutory functions pertain to registering health professionals,<sup>33</sup> setting standards, dealing with complaints and concerns about the conduct or performance of health professionals and protecting the public to ensure that only safe health practitioners are registered.
66. Relevantly, AHPRA’s powers include control over which medical practitioners may practice, investigating complaints against a medical practitioner, taking disciplinary action against a medical practitioner and imposing conditions and suspension upon a medical practitioner. AHPRA has broad powers to prevent a medical practitioner from practising, including immediately, if there is a serious risk to public safety.
67. The involvement of AHPRA is referred to in this finding. In March 2017, about six months after Mr Brown’s death, but unrelated to his death, a pharmacist dispensing for another of Dr Jackson’s patients, PX, reported Dr Jackson to

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<sup>32</sup> G 32 Affidavit of Dr Reynolds 12 September 2022.

<sup>33</sup> Including nurses.

AHPRA.<sup>34</sup> The complaint was that Dr Jackson prescribed excess takeaway doses to his patient, PX, who was participating in ORT.

68. Then, on 10 January 2018, following gathering further evidence in the coronial investigation into Mr Brown's death, Tasmania Police made a notification to AHPRA in respect of Dr Jackson.<sup>35</sup> In that notification, Tasmania Police advised AHPRA that investigations into the deaths of Ms Kemp and Mr Winwood were also considering Dr Jackson's prescribing as their deaths were apparently from prescription drug overdose.
69. As a result of that notification, AHPRA moved immediately to prohibit Dr Jackson from prescribing Schedule 8 and Schedule 4 drugs.
70. In imposing these restrictions, AHPRA determined that Dr Jackson: *"...posed a serious risk to persons, by failing to carry out proper medical assessments; prescribing methadone at a dosage that is inappropriate and in a manner that is inappropriate; inappropriately combining opioids with benzodiazepines and contravening the TOPP and Code of Conduct. The practitioner's performance may have contributed to the death of at least three patients and the non-fatal overdose of another."*<sup>36</sup>
71. On 16 January 2018, in response to the action of AHPRA, Dr Jackson provided AHPRA with a formal undertaking that he would not practice medicine.<sup>37</sup> There is no evidence that he has applied to be again registered as a medical practitioner or that he has practiced medicine since that time.

### **Evidence in the investigation**

72. The evidence comprised documentary exhibits and oral testimony from witnesses at inquest.
73. The exhibit lists for Mr Brown, Ms Wiki, Mr Winwood, Ms Kemp and general exhibits relating to all four deceased are annexed to these findings and marked 'A'.
74. Of the many witnesses who provided affidavits, statutory declarations, statements or reports in documentary form, 44 witnesses were called to give

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34 G4-10 and G16-38 AHPRA notification to Dr Jackson.

35 G4-12.

36 G4-12 page 12.

37 G4-12 page 2.

evidence at inquest. The names and positions of these witnesses is annexed to these findings and marked 'B'.

75. Further, investigation reports for Mr Brown, Ms Wiki, Mr Winwood and Ms Kemp amounting to jointly over 260 pages, were provided to all counsel as an aid to the exhibits but were not tendered in the inquest. The reports were prepared by Detective Senior Constable Nelsen, Detective Senior Constable Bovill and Detective Senior Constable Kathryn Barwick<sup>38</sup> The reports, whilst the contents do not amount to evidence in the investigation, have been very useful to navigate the very large body of evidence. Further, there has been no submission, or even suggestion, that the reports contain inaccurate representations of the evidence tendered at inquest.
76. Significant consideration was given to whether the inquest should hear from patients or former patients of Dr Jackson, still living, regarding his treatment practices for patients on ORT. As noted, it was proposed by the investigators that many living patients providing "tendency and coincidence" evidence in the criminal prosecution which did not proceed. Ultimately, I decided that it was preferable not to focus, with a large amount of hearing time associated, upon Dr Jackson's treatment of others, even though other patients may have assisted.
77. During the inquest, the proposal by counsel assisting to call one particular "living" patient for evidence akin to tendency evidence was opposed by counsel for Dr Jackson and counsel for the Salvation Army. I ruled that, on balance, I would not gain considerable assistance by hearing from the patient or a number of others. Nevertheless, an affidavit of patient LF was tendered without her being called as was a series of emails between another patient, Rosalie Yeo, and Dr Jackson. Finally in this category, PX gave evidence in addition to providing an affidavit.<sup>39</sup>

## Interested parties

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<sup>38</sup> Now Sergeant Barwick.

<sup>39</sup> T1553 and G16-1.

### *Procedural fairness*

78. The coronial process, including an inquest, is subject to the requirement to afford procedural fairness.<sup>40</sup> Specifically, section 52 of the Act provides that a person with a sufficient interest may be represented by a legal practitioner, call and examine or cross-examine witnesses, and make submissions, at an inquest.
79. Generally, any person (including any legal entity) who might be the subject of an adverse finding or comment will have a sufficient interest. In the context of many coronial inquiries, adverse comment may mean criticism of a person or organisation for deficits in procedures or failure to adhere to prescribed standards which may be connected to a death. The class of persons who have a sufficient interest under section 52 extends to family members.<sup>41</sup> The section allows the coroner some discretion regarding determination of sufficiency of interest.
80. Importantly, however, all parties identified as potentially being subject to adverse comment were provided with full disclosure of the evidence well prior to inquest, and were legally represented. These parties, through their legal representatives, were provided with a full opportunity to examine witnesses, call witnesses and make submissions.
81. For ease of reference, it is convenient to set out those parties with sufficient interest and to identify the main issues raised by them.
82. In dealing with the interested parties, I will detail comprehensively Dr Jackson's background, evidence and discussion regarding his credibility. This is necessary to understand the circumstances surrounding each death and the analysis of the facts. I will also set out the same general matters regarding Mr Jacometti for the same reasons.

### *Dr David Jackson*

#### Introduction

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<sup>40</sup> See *Annetts v McCann*, (1990) 170 CLR 596.

<sup>41</sup> *Annetts v McCann*, supra.

83. This inquest is, and must be, focused on the four deaths and the coroner's functions under section 28 of the Act. To acquit the coronial functions, it is necessary to examine the involvement of Dr Jackson.
84. Unlike many inquests, I have found it necessary to consider in some detail Dr Jackson's prior practices and motivations in order to properly understand his treatment of each of the deceased in the period leading up to, and surrounding, their deaths. Before addressing the circumstances of the deaths of Mr Brown, Ms Wiki, Mr Winwood and Ms Kemp, I will deal with the evidence on this issue.
85. The evidence discloses features of Dr Jackson's conduct as a medical practitioner that cause me to question how, for so long, he maintained his registration, or at least his authority to treat patients on opioid replacement therapy (ORT) and to prescribe opioids. The following discussion necessarily focuses on adverse aspects of his practice in addiction medicine, as they are directly relevant to the treatment and prescribing decisions associated with each death.
86. The evidence tendered at inquest about Dr Jackson's prescribing practices and attitude to standards and guidelines, is relevant to explain and understand the circumstances surrounding the deaths and, if sufficiently connected to death, to consider making comments and recommendations. It should be noted that a large amount of documentary material gathered in the investigation that does not materially assist me in my functions has not been included in the evidentiary exhibits. I do not have a statutory mandate to conduct a stand-alone inquiry into Dr Jackson's prescribing and treating practices. It is also no doubt possible that, over the years, Dr Jackson may have assisted in positive outcomes for patients.
87. However, Dr Jackson's involvement with the four deceased cannot be viewed in a vacuum. The matters from the evidence that I outline below are important because they demonstrate, among other relevant matters, Dr Jackson's propensity to engage in an unusually high degree of conflict with colleagues; and also concerns by some senior members of the medical profession for many years before the deaths regarding his permissive approach to opioid prescribing.
88. It is not the role of the coroner to exercise or comment upon disciplinary functions in respect of a medical practitioner. However, I have found it

necessary at times to recount Dr Jackson's involvement with AHPRA to the extent that it touches upon matters relevant to this inquest.

89. At the beginning of his evidence at inquest, Dr Jackson specified that he should not be referred to as Dr Jackson because he was concerned about the attitude of AHPRA and any consequent fine if he sanctioned the use of the title when he is no longer a medical practitioner.<sup>42</sup> Nevertheless, it is preferable that I refer to him in this finding by his medical title as, during the period of his treatment of the four deceased, he was a registered medical practitioner.
90. Dr Jackson was born on 12 July 1951. He lived in West Hobart until 2018, when he moved to Magnetic Island in North Queensland where he is currently residing with his wife.
91. Dr Jackson graduated from Monash University, Victoria in 1974 with a Bachelor of Medicine and Bachelor of Surgery. He then gained an internship in 1975 at Warrnambool District Base Hospital in Victoria. From 1976 until 1986 he worked as a general practitioner at Timboon in Victoria. In 1982 he was admitted as a Fellow of the Royal Australian College of General Practitioners (FRACGP).<sup>43</sup>
92. He transferred to Tasmania in 1986, where he was appointed as a medical officer at the Royal Hobart Hospital ("RHH"). He worked in this position for a year before moving on to other positions, mostly in the alcohol and drugs area, dealing with addiction.
93. In 1992, Dr Jackson came to the attention of senior health staff for prescribing excessive opioids to patients. At this time, he was employed at John Edis Hospital in New Town.<sup>44</sup> Senior staff, including the then Chief Pharmacist, John Galloway, and the Superintendent of the hospital, Dr Carol Ryan, considered there were significant concerns about his prescribing. Following discussions with him, Dr Jackson accepted that he had prescribed unwisely on some occasions.
94. Controls were then placed upon Dr Jackson whereby he agreed not to supply or prescribe narcotic drugs to alcohol and drug service patients except methadone in the form of the syrup administered daily under supervision in

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42 T2352.

43 G4-1.

44 A former psychiatric or drug and alcohol rehabilitation facility.

accordance with the policy and procedures on methadone maintenance. He agreed that he would not breach these controls.<sup>45</sup>

95. Mr Galloway said in correspondence to Dr Ryan at that time *"I indicated to Dr Jackson that in my view, the matter of prescribing drugs of addiction for take away use is of such importance as to warrant close monitoring."*<sup>46</sup>

96. In 1995, Dr Jackson again came to the attention of the Chief Pharmacist relating to excessive prescribing of methadone. In a contemporaneous report to "State Program Co-ordinator CFCS" Mr Galloway stated:<sup>47</sup>

*"In the case in question, Dr Jackson is making methadone tablets available in the belief that a sufficient case has been made that they are necessary for treatment of his client's pain. Dr Jackson's judgement, however, is not supported by (a) the opinion of mainstream medicine on the treatment of this type of condition, (b) a specialist's assessment of this patient's condition and (c) the opinion of the section 22 committee which twice considered the case."*

97. Mr Galloway goes on to state:

*"As you know, prescribers are subjected to extraordinary pressures by clients over a long period of time and it is not humanly possible for anyone to hold to a clear objective professional position when constantly faced with these pressures. It concerns me greatly that there is no system of clinical leadership or peer review which prevents inappropriate departures from accepted policies and practices. Clearly, when such departures are contemplated, there should be a system of consultation with an expert who is at arms length or at least peer discussion prior to implementation. Essentially, the current lack of accountability can lead to wrong or misguided decisions, and to unscientific and unsound medical treatment. There is also a need to provide a professional support structure to manage the inevitable stresses created by demands by clients for drugs of choice."*<sup>48</sup>

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45 G 4-37 page 7-8.

46 G4-37 page 3.

47 G4-37 page 25.

48 G4-37 page 26.

98. Mr Galloway stated in his report that there was no mechanism for review of Dr Jackson's prescribing but recommended a review of prescribing by ADS and referral of the case to a pain management centre.
99. In 2002, Dr Jackson gained Fellowship of the Australasian Chapter of Addiction Medicine (FACHAM).
100. From 2002 to 2006, he served as the Clinical Director of the Alcohol and Drug Service, Department of Health and Human Services in Tasmania. He resigned from that appointment because, inter alia, he was dissatisfied with the working conditions. Concluding his resignation letter, he wrote "*... I regret that I could not be leaving with a less bitter view of the Department or indeed, that I am leaving at all.*"<sup>49</sup>
101. Dr Jackson then worked in various medical practices and community centres over the next few years, primarily as an addiction specialist.<sup>50</sup>

#### Dr Cerchez's involvement with Dr Jackson

102. One particular period in Dr Jackson's professional life is highly instructive in both his approach to the inherently high risks of prescribing Schedule 8 opioids and his propensity to initiate unnecessary conflict. It relates to a relatively short period in 2007<sup>51</sup> where Dr Jackson had involvement as a colleague with Dr George Cerchez at the Clarence Community Centre, a medical practice. Dr Jackson did not have pharmacotherapy (ORT) patients at this practice but the evidence remains particularly relevant to issues within the scope of the inquest.
103. After resigning as Clinical Director of ADS in 2006, Dr Jackson commenced working at the Clarence Community Health Centre. In early 2007, or thereabouts, Dr Cerchez was appointed to the role of senior medical officer at the practice and was specifically brought in to "*fill in with gaps in the leadership of the medical practice.*"<sup>52</sup>
104. Dr Cerchez is a very experienced general practitioner and at the date of making his affidavit in 2019, he had 44 years of experience in both private practice and in the Department of Health in Tasmania.

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49 G4-3 page 10.

50 G4-4 page 45.

51 Likely a period of up to 4 months (with regards to the affidavit of Dr Cerchez G19 and Dr Jackson's curriculum vitae G36b.

52 G19, page 1.

105. In 2007, Dr Jackson's prescribing practices again came under scrutiny from Dr Cerchez who gave evidence by affidavit and at inquest.<sup>53</sup>
106. In his statutory declaration, Dr Cerchez explained his leadership role and his contact and interactions with Dr Jackson as follows:

*"I recall Dr David Jackson was working at the centre when I was there. I recall that there was a "known problem" with drug addicted patients attending the centre. The centre was known as being "an easy place" to get more drugs and some doctors at the clinic were known as "easy". At the time it was a bulk billing practice.*

*I had been asked to review the centre's practices and noticed that Dr David Jackson appeared to be increasing the doses of his pharmacotherapy patients. Dr Jackson kept limited notes in relation to treating his patients. This made it hard to review them and understand the logic behind why he was prescribing high doses.*

*I called a clinical meeting in 2007 for all of the doctors to attend due to my concerns surrounding the known issues at the clinic. It was at this meeting I advised all staff that were treating pharmacotherapy patients that they had to develop a care plan for each patient they treated and for a need to gradually decrease the addictive medications. All of the doctors were present and an agreement was reached that this reduction strategy would occur. All other doctors complied except Dr David Jackson who increased patients' doses. I could never understand Dr David Jackson's logic."<sup>54</sup>*

107. In his oral evidence at inquest, Dr Cerchez gave clear, intelligent evidence, which I found to be both logical and temperate. He did not seek to reconstruct beyond his actual memory of relevant events. I have no hesitation in accepting his evidence in its entirety.
108. Dr Cerchez said at inquest that Dr Jackson's practice was inconsistent with normal, proper practice in the area – he kept unsatisfactorily limited patient notes, he prescribed drugs of addiction too freely, with too high doses and unnecessary benzodiazepines. He emphasised the dangers of adding benzodiazepines.

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53 G19 Statutory Declaration 29 Aug 2019 and T 2298 – 2315.

54 G19, paragraphs 5-7.

109. At the inquest, Dr Cerchez said in evidence:

*“Certainly, I tried on many occasions to understand his [Dr Jackson’s] clinical logic behind his medication prescription practices and he could offer no significant logical explanation for it and I could never understand why he might increase dosages for patients who had not even requested it.”*<sup>55</sup>

110. Dr Cerchez gave evidence that he formed his views regarding Dr Jackson’s prescribing practices over time and only after several meetings with Dr Jackson where it became apparent that, unlike the other doctors, he would not comply with the patient management plans. I infer from Dr Cerchez’s evidence that his personal meetings with Dr Jackson were prior to the meeting Dr Cerchez held with all of the doctors referred to above. I accept the evidence of Dr Cerchez that Dr Jackson left the practice very shortly after that meeting<sup>56</sup> to practice at Rosny Doctors and Travel Clinic because he would have been curtailed in his opioid prescribing practices if he remained practising at the Clarence Community Centre.

111. After Dr Jackson left, Dr Cerchez consulted with five of Dr Jackson’s former patients in the medical centre to whom opioids had been prescribed. Following the consultation, Dr Cerchez formed the following views:

- No other strategies were being considered for their anxiety or pain management other than medication;
- Some patients were unsure why their dose was increased;
- There were no attempts to reduce the dose even if the cause of pain was limited (for example, a fracture);
- Very limited documentary records existed; and
- There was little regard to past history of drug abuse or the personality of patients.<sup>57</sup>

112. At the time, Dr Cerchez provided written details of the issues to Dr Reynolds, Clinical Director of ADS, describing Dr Jackson as engaging in “*extremely irregular prescribing*”.<sup>58</sup>

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55 T2311.

56 G19.

57 G19 at page 3.

58 G19, refer to attachments to statutory declaration: email 26 April 2007 and memorandum prepared by Dr Reynolds dated 28 May 2007.

113. Dr Cerchez said that Dr Jackson was often asked for by name by patients who exhibited drug seeking behaviour. When told that Dr Jackson was no longer at the centre most of these patients discontinued attending.<sup>59</sup>
114. Dr Jackson, in his evidence, responded to the evidence of Dr Cerchez in what I considered to be a most unhelpful and defensive manner.
115. Despite the affidavit and detailed inquest evidence from Dr Cerchez regarding this significant management review, Dr Jackson said he had no memory of any dispute with Dr Cerchez regarding the way he (Dr Jackson) was treating patients.
116. Dr Jackson's inquest evidence about this matter discloses not only an inability to recall the matter objectively, but his intransigence in the face of attempts to encourage him to comply with basic safe prescribing practices. His attitude was one of "knowing best" how to prescribe opioids and he was being unfairly targeted for doing so.
117. The following passage from his evidence represents Dr Jackson's dismissive attitude towards Dr Cerchez, his lack of clarity of thought and his poor insight into his own practices:

*"Well subsequently I I've seen a I think bizarre ah affidavit from Dr Cerchez where he claims that – well he claims that I had pharmacotherapy patients but I never had a single – pharmacotherapy but another term for methadone maintenance. I never had a single ah pharmacotherapy patient at that– at that clinic. Um so I I don't know what he was on about. I think – like I think in his affidavit one thing that really struck me he's – I think – or it might've been notes taken by Dr Reynolds in a phone discussion with Dr Cerchez that Dr Cerchez said he pleaded with me to stay, which is true. He pleaded with me to stay at the clinic but then he came up with all this stuff about what a ratbag I was. I never could get my head around that. I think it was in his first – I think it was in the notes taken by Dr Reynolds that he pleaded for me to stay and he did plead and he was very upset that I left because um even though I say it myself I was a popular doctor at the clinic."<sup>60</sup>*

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59 T2305.

60 T2392.

118. It appears that upon Dr Cerchez communicating prescribing issues to the doctors and implementing the requirement of management plans, Dr Jackson took great umbrage and quite suddenly tendered his resignation, indicating that he was being “victimised”. It is in that context that Dr Cerchez tried to dissuade him from leaving, no doubt considering that the issues might be resolved sensibly.<sup>61</sup>
119. I find that Dr Cerchez did personally speak to Dr Jackson about his prescribing practices. I accept his evidence that Dr Jackson explained them by indicating that he prescribed as clinically necessary and that he was an expert in the field of addiction medicine. Dr Cerchez did say that Dr Jackson would appear to agree with what was being said but this did not lead to any behaviour change and he (Dr Cerchez) would continue to receive complaints from other doctors about Dr Jackson’s practices in providing drugs of addiction too freely, in excessive doses, and adding in benzodiazepines and other sedative drugs.<sup>62</sup>
120. Dr Jackson vehemently denied that Dr Cerchez spoke to him at all about the need to improve the safety of his prescribing practices, giving evidence that Dr Cerchez was confusing him with a doctor called “Steve”. Dr Jackson said in evidence about “Steve”:
- “Steve. Um no it totally escapes me but I know there was – I think it went to the Supreme Court between him and Dr Cerchez but he was brought in to try and control that doctor. Dr Cerchez employed me. He was the – he was the clinical director, senior medical officer or whatever when I started there. He wasn’t brought in to change my habits and he never spoke to me about them and that’s a clear memory. He never once approached me about it.”<sup>63</sup>*
121. Dr Jackson added to this evidence by most ungraciously stating: *“I hate to say it, but Dr Cerchez is known to have quite severe brain damage”* and that his memory is *“not as good as it should be”*.
122. As with much of Dr Jackson’s other evidence, there was also a willingness to unfairly and personally denigrate those who sought to challenge him.

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61 G19 page 16.

62 T2302.

63 T2394.

123. None of these matters were put to Dr Cerchez in evidence and therefore he did not have a chance to respond. However, as stated, I have no hesitation in accepting all of the evidence of Dr Cerchez and rejecting the confused and accusatory evidence of Dr Jackson where it conflicts with that of Dr Cerchez. In fact, his allegation that Dr Cerchez suffered brain damage is little short of scandalous.
124. Dr Jackson's counsel made application to exclude evidence relating to the involvement of Dr Jackson with Dr Cerchez in 2007. I ruled, accepting the submissions of counsel assisting, that the evidence was relevant in providing assistance with issues surrounding his prescribing to each of the four deceased.
125. Although the involvement of Dr Cerchez was almost 10 years before the death of Mr Brown, the evidence is most important to inform the unsafe and permissive manner in which Dr Jackson habitually prescribed, did not take well-meaning professional advice and was irrational and somewhat paranoid in his professional dealings.
126. In 2008, Dr Jackson was involved in a disagreement with PSB regarding the continued prescribing of opioids for the pain management of a patient, WB. Exchanges of correspondence were part of the evidence at inquest and it is plainly apparent that Dr Jackson escalated the matter in an unreasonable and inflammatory way with senior health professionals, writing to PSB a letter rejecting the terms of the Schedule 8 authority issued by PSB, which included the following:

*"I intend also to offer my services to WB as his advocate for a complaint on your decisions to the Health Complaints Commissioner.*

*Given my failure to accept your decision you will now have to withdraw my right to prescribe to WB. I would like to remind you – or inform you as I suspect you are unaware – that the sudden cessation of opioids in a chronic pain patient who has been on opioids long-term substantially increases the risk of suicide."<sup>64</sup>*

127. Following further antagonistic correspondence by Dr Jackson over the ensuing months rejecting PSB's requirements, including the requirement that he provide a pain specialist report for WB as a supporting document, Dr Jackson

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64 G4-28 letter 14 January 2008.

eventually had a conversation with the Chief Pharmacist at PSB, Ms Mary Sharpe, on 3 April 2008.

128. Ms Sharpe contacted Dr Jackson in an attempt to resolve the issue of the application by Dr Jackson to prescribe opioids for WB. However, in that conversation, when Ms Sharpe challenged Dr Jackson on the role of ADS with the patient, Dr Jackson swore at her and called her derogatory names.
129. On 8 April 2008, Dr Reynolds subsequently sent an email to Dr John Crawshaw, head of Mental Health Services, Department of Health and Human Services<sup>65</sup> which in part stated:

*"I am concerned about damage he may do to others and to ADS before it all catches up with him. I wonder about our duty of care to him in context of his care of patients who are of mutual concern..."*<sup>66</sup>

130. In another email that day, Dr Reynolds said to Ms Sharpe, copying in Dr Crawshaw and Dr Roscoe Taylor, Director of Public Health and Director Population Health, stating:

*"... Things seem to be deteriorating with Dr J. [Jackson] I wonder how long we go on without taking some form of definitive action. How well is he able to care for his patients right now?"*<sup>67</sup>

131. On 22 April 2008 Dr Taylor sent a letter to Dr Jackson (who had made a complaint to him) thanking him for forwarding the specialist report required for the authority and advising him that he could prescribe to WB for another 12 months. In the letter he also stated:

*"...you have made a number of statements in respect of the conduct and credibility of a number of Departmental members. I am not prepared to comment on these statements other than to say that I continue to have confidence in the professionalism and ability of these officers..."*<sup>68</sup>

#### Dr Jackson's commencement at the Hobart Clinic and Bridge Centre

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65 Dr Crawshaw's role is stated in Report: Inquiry into Mental Health Services in Australia.

66 G4-27 at page 1.

67 Ibid.

68 G4-33 at page 2.

132. In 2011, Dr Jackson commenced employment at the Hobart Clinic at Rokeby. He was employed as a general practitioner on a part time basis to perform duties and assist in the management of inpatients with drug and alcohol problems. He treated additional private patients from his office at the clinic.
133. In 2012, Dr Jackson also began working at the Salvation Army Bridge Centre for one day a week, whilst still also practising out of the Hobart Clinic.
134. At the Bridge Centre, Dr Jackson worked very closely with registered nurse, Mr Nikolaas Azon-Jacometti (“Mr Jacometti”).<sup>69</sup>
135. Mr Jacometti was employed by the Salvation Army at the Bridge Centre as a home-based withdrawal nurse. He assisted Dr Jackson whilst meeting with patients and also acted as a conduit between Dr Jackson and his patients. During an interview with investigating police officers, Mr Jacometti indicated that he had first encountered Dr Jackson whilst working with him at the Emergency Department at the RHH. Whilst at an Alcohol, Tobacco and Drug Council Conference he had a conversation with Dr Jackson about working together to *“help people that failed withdrawal.”*<sup>70</sup>
136. Mr Jacometti subsequently had meetings and discussions with Dr Jackson to see whether they could work something out to stop this category of patients *“falling through the cracks”*.<sup>71</sup> I accept Mr Jacometti’s account about how the concept of the working relationship was formed.
137. In line with the plan, Dr Jackson began working at the Bridge Centre one morning a week with the assistance of Mr Jacometti.
138. Dr Jackson’s work at the Bridge Centre was in a volunteer capacity as a general practitioner where he conducted a “walk in” clinic for clients with opioid addiction one morning a week. Even though he worked from the Bridge Centre building in Lenah Valley, he operated independently as a private medical practitioner and not subject to directions, rules or procedures of the Salvation Army program. Dr Jackson remained working at the Hobart Clinic and was treating ORT patients.
139. In March 2017, AHPRA received an anonymous notification from a pharmacist. That pharmacist was Conan Ziegler. The notification was that Dr Jackson had

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69 Date of birth 13 March 1954.

70 NB16a at page 18.

71 Ibid.

prescribed excess takeaway doses to PX<sup>72</sup> during February 2017.<sup>73</sup> Mr Ziegler was Pharmacist Manager at Terry White Kingston Pharmacy and PX was an ORT patient of Dr Jackson. Both Mr Ziegler and PX swore affidavits during the investigation and both gave articulate, comprehensive and credible evidence at inquest.

140. Mr Ziegler said in his affidavit:

*"I have been dispensing Subutex/Suboxone to PX for 1.5 years. I would often chat to her and ask how she was and occasionally she would make comments like she hadn't seen Dr Jackson for a while. This raised alarm bells with me as I had thought he should be seeing her regularly. Around November/December 2017, PX disclosed to me that she had been admitted to hospital after an overdose.*

*I am aware of the Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards (commonly known as TOPP guidelines) and the responsibilities placed on doctors and pharmacists. I am aware of the guidelines surrounding the prescribing of takeaway doses.*

*I have had concerns in relation to Dr Jackson's prescribing of medications for PX. On 11<sup>th</sup> April 2017 I contacted Dr Jackson about excessive takeaways and diazepam early supplies. He advised he will not do anything until after Easter. I also contacted AHPRA about my concerns. I made a note of this in PX's patient notes on the Minfos software. On 11<sup>th</sup> December 2017 I contacted PSB, Dr Natalie at ADS and Dr Jackson about PX's recent overdose on paracetamol and Seroquel and ending up in the RHH. I was concerned that Dr Jackson had reinstated 1+1 TADs a week or so after this and her still being on 30 mg of diazepam/day. Dr Jackson indicated to me that he was okay with her receiving these takeaways even after I had voiced my concerns. He further said that overdose risk of PX's Suboxone/diazepam was not serious and that panamax, etc. was more dangerous."<sup>74</sup>*

141. In his evidence at inquest, Mr Ziegler said he had not called PSB before or after this date to report prescribing behaviours of any other medical practitioner. He

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72 Born 1985, not deceased.

73 G4-10 page 1.

74 G16-39.

has also never before or since reported a prescriber to AHPRA. He explained that he was not used to seeing such a large number of takeaway doses.<sup>75</sup>

142. In her evidence at inquest, PX described going to Dr Jackson at the Hobart Clinic<sup>76</sup> and Salvation Army<sup>77</sup> and he put her on the suboxone program. She said she did not see Dr Jackson much, only three or four times in her five years on suboxone program.<sup>78</sup> She first received Valium (the benzodiazepine diazepam) legally when it was prescribed by Dr Jackson. She said that he would just prescribe what she wanted. She said that she initiated increases in doses by telephoning him and he would do it without seeing her. She would also tell him she lost the takeaway doses and Dr Jackson would replace them without asking. She said that Dr Jackson increased her Valium to up to 100 per fortnight so she would not pester him.<sup>79</sup>
143. PX said that she still used illicit drugs at the same time she was receiving four consecutive takeaway doses. She said that she also took Seroquel from Dr Stuart Hooper, psychiatrist.<sup>80</sup> She said that the suboxone changed her life considering the extent of her addiction. She said that her conversations with Dr Jackson on the phone were five-minute calls.<sup>81</sup>
144. In addition to rarely seeing PX in person, Dr Jackson did not require her to submit to any urine or blood tests for drug screening.<sup>82</sup> Further, Dr Jackson not ever request access to DORA,<sup>83</sup> being this state's (then) real time prescription monitoring system, which would enable prescribers and dispensers to view important Schedule 8 prescribing and dispensing data so that such substances can be safely supplied.<sup>84</sup>
145. She said in her affidavit "*Dr Jackson was known around the traps as "The Pill Doctor". People would say they could get anything from him and would ask how they could get in touch with him.*"<sup>85</sup>

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75 T1135.

76 T1554-5.

77 T1556.

78 T1558

79 T1563.

80 T1565.

81 T1583.

82 G16-1 at paragraph 13- Affidavit of PX.

83 Drugs and Poison Information System Online Remote Access.

84 G16-2 page 4.

85 G16-1 page 4.

146. On 13 April 2017, AHPRA sent a letter to Dr Jackson advising him that an anonymous complaint had been made about his performance as a doctor.<sup>86</sup>
147. He was advised that if he wished to respond to the allegation, he had until 9 May 2017 to submit his response.
148. Dr Jackson raised the matter with PX following becoming aware of AHPRA's involvement. I fully accept PX's astonishing account of the phone conversation set out in her affidavit:

*"In early 2017 I recall speaking to Dr Jackson on the phone asking for extra takeaway doses and he said to me "in confidence" that he was being investigated by an ex-Sergeant or Constable and was now only allowed to give me 4 take aways at a time. I was then not able to contact him and get any extra take aways on top of the four I had already received, this included if I was to be going away for a weekend."<sup>87</sup>*

149. On 20 April 2017, Dr Jackson phoned AHPRA, asking what his obligations were with regards to providing clinical records for the patient PX. The contents of this conversation were recorded in a file note made by a staff member of AHPRA.<sup>88</sup> Dr Jackson questioned:

*"...if this is a national scheme why he would be held to a different standard than a doctor in Queensland in that he is allowed to provide 30 take away doses for a medication in QLD but gets 'punished' for doing so in Tasmania."*

150. Dr Jackson wrote to AHPRA on 5 May 2017 explaining his prescribing for Ms PX and why he prescribed more takeaways than permitted under the TOPP. In the letter, Dr Jackson listed his credentials. He wrote that he currently prescribes for 50 such patients, stating, inter alia, the following:

*"...The overarching aim of the treatment is to allow the people who suffer this severe, life threatening chronic disorder to lead a life as normal as possible..."*

*...I am a registered prescriber of methadone and buprenorphine in Queensland as well as Tasmania, Victoria, South Australia and Western*

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<sup>86</sup> G16-38.

<sup>87</sup> G16-1 at page 4. I note that a police officer (or former police officer) was working as an investigator for AHPRA at the time.

<sup>88</sup> G4-10 at page 2.

*Australia. When PX or any of my other patients spend time in, for example, Queensland, I am able to prescribe 31 consecutive doses before a supervised dose is expected, and this with no need to refer to work or other patient commitments...*

*... My confusion stems from my difficulty in understanding how common given the implications of the complaint, my clinical judgment can be inadequate in Tasmania but not in other parts of Australia, and furthermore that I can be a danger to the public in Tasmania but not in Queensland, when practising identically in both places. In other words, it starts to look like a state political issue rather than a good clinical practice one.*

*... In addition, my long experience in the work I do has caused me to not subscribe to the common view that one must “never trust a drug addict as they always lie.”<sup>89</sup>*

151. There was no evidence that Dr Jackson had the right to prescribe interstate. It is relevant that his correspondence and discussions were concerned with justifying what he saw as high-quality treatment and the unreasonableness of the restrictions. His correspondence very clearly conveyed that he was content with his treatment and customised care management plan for PX over a period of four years.<sup>90</sup> He did not consider that he had put her at risk in any way nor breached his duty of care. In fact, he said that the treatment had successfully allowed her to function in her business and all aspects of her life.<sup>91</sup>
152. AHPRA sent a letter to Dr Jackson on 19 July 2017 advising him of the Board’s decision to investigate his actions with regards to his prescribing of PX.<sup>92</sup>
153. On 15 December 2017, AHPRA wrote to Dr Jackson following its initial investigation into PX, and advised him that it had identified 12 breaches of the TOPP. AHPRA requested a response from Dr Jackson with regards to these breaches.<sup>93</sup>
154. On 27 December 2017 officers of Tasmania Police, as Coroner’s Officers, executed an order under section 59 of the *Coroners Act* 1995 at the private

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89 G4-10 p.3-6.

90 G16-2 PSB report gives the period of Dr Jackson’s treatment of PX November 2013 – March 2018.

91 Ibid.

92 G4-11.

93 G4-13 p.6-10.

residence of Dr Jackson. The order authorised the officers to enter, search for and seize any evidence relating to any consultations or treatment, including prescriptions for Mr Brown. At the time of the search, Dr Jackson was not present, although family members were present during the search.

155. This search was made necessary because Dr Jackson failed to produce to the Coroner his records for Mr Brown despite being requested to do so shortly after his death on 27 September 2016.
156. As a result of this search, the officers located a file relating to Mr Brown in an open unlocked office area of the residence. This file had not been previously disclosed to the Coroner, as requested, to assist in the investigation. The 2016 letter requesting production of the documents to the coroner was found within Mr Brown's patient file, along with The Mercury newspaper's death notices dated 6 October 2017. I find that Dr Jackson ignored the Coroner's Office request for a copy of Mr Brown's patient records. These were subsequently seized by police during the search on 27 December 2017.
157. With this file, the officers located three other patient files, relating to PX, Mr Winwood and Ms Kemp. As a result of these additional patient files being located, further Coroner's Orders authorising seizure were made.
158. Later that day, police officers attended the Hobart Clinic at Rokeby to execute another section 59 Coroner's Order to search for and seize additional records of Dr Jackson's private patients. The officers seized documents from a secure filing cabinet belonging to Dr Jackson relating to Mr Brown, Mr Winwood and Ms Kemp. Dr Jackson had also failed to disclose these records to the Coroner when requested.
159. Two days later, on 29 December 2017, Dr Jackson rang Tasmania Police from the United Kingdom, where he was currently on leave, and outlined that he had been suspended from practising at the Hobart Clinic.
160. On 10 January 2018, by lengthy correspondence, a Tasmania Police coronial investigator, Detective Senior Constable Claire Lowe, reported Dr Jackson to AHPRA in respect of the death of Mr Brown. Detective Lowe also advised AHPRA that three other deaths of Dr Jackson's patients had occurred subsequent to the death of Mr Brown on 27 September 2016 and in each case the deceased appeared to have consumed an overdose of methadone.<sup>94</sup>

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94 NB66h.

161. On 11 January 2018, AHPRA again wrote to Dr Jackson informing him that on 10 January 2018, Tasmania Police notified them he was being investigated due to a coronial matter. AHPRA advised Dr Jackson he may make submissions to the Board for their consideration which will enable them to make a decision on what action to take with regards to his future practice. He was given until 16 January 2018 to respond.<sup>95</sup>
162. On 12 January 2018, Dr Jackson's lawyers sent correspondence to AHPRA advising of Dr Jackson's formal resignation from practising medicine, citing notices issued to him by AHPRA dated 15 December 2017 and 11 January 2018, regarding the PX investigation and the police coronial investigation into the death of Nicholas Brown respectively.<sup>96</sup>

Dr Jackson's evidence regarding his views and general practice of pharmacotherapy

163. Dr Jackson's evidence was provided in two affidavits. The first dated 17 February 2017<sup>97</sup> and the second affirmed 21 November 2022.<sup>98</sup> He also gave evidence orally in Court over four days.<sup>99</sup>
164. Dr Jackson's evidence was given in a highly emotive fashion and was difficult to follow. It included significant instances of quite irrational hyperbole and the offering of statistics and anecdotes that were not supported by any evidence. Consistent with his approach already described, he expressed paranoia in relation to authorities and other medical professionals. He disagreed on many occasions with views held by the mainstream medical community that were unequivocally supported by scientific evidence. He demonstrated an excellent memory in relation to many details of his practice and events pertaining to particular patients. However, when questioned about matters regarding his practice where the answer may have been against his interests, he often found it difficult to recall or gave a vague or irrelevant answer.
165. A significant theme of his evidence was his view that the TOPP was overly prescriptive, convoluted and unclear and compared to other guidelines was not useful for everyday practice and was completely out of date.<sup>100</sup> He adhered to his position that every non-government alcohol and drug organisation boycotted

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95 G4-13 p.11-19.

96 G4-12 page1-2.

97 NB13.

98 G36a.

99 30 May, 22 June, 12 September, 13 September 2023.

100 Ibid paragraph 5.

the launch of the TOPP as there was intense ill feeling about its genesis.<sup>101</sup> I will deal with this assertion further, but I do not accept at all that the introduction of the TOPP was met with such intense or widespread disapprobation.

166. In order to understand Dr Jackson's prescribing to each of the deceased, it is important to set out in some detail the views of Dr Jackson. Counsel assisting, in their closing submissions, conveniently summarised the aspects of Dr Jackson's evidence, prescribing and treatment practices most relevant to the issues at inquest. The summary below closely follows, and in some parts replicates, those unchallenged passages from counsel assisting's submissions.
167. I also preface this summary of Dr Jackson's evidence by saying that over the course of the whole inquest process, from the time of his initial contact with coronial investigators until the conclusion of his oral evidence at inquest, his views about the correctness of his own practices did not change despite AHPRA's involvement and his awareness of numerous expert views contrary to his own.
168. In his affidavit of 21 November 2022, Dr Jackson said the following:
- a. He had no problems with prescribing benzodiazepines to patients along with methadone as, in his opinion, this is still a valid treatment method.<sup>102</sup>
  - b. His view was that due to tolerance to the drug, a patient with a longstanding anxiety disorder was unlikely to be able to get off benzodiazepines. He said that the "*five year success rate*" for patients with addictive disorders being is "*about zero*."<sup>103</sup>
  - c. That he wanted his patients to live as normal a life as possible and a normal life is not going to the pharmacy every day to be treated. Therefore, his practice was to provide as many take-away doses as he considered were appropriate and safe for that patient.<sup>104</sup>
169. In his evidence in court, commencing on 30 May 2023, Dr Jackson gave a lengthy account of his history as a practitioner in addiction medicine and his views on the evolution of that medical specialty. Relevantly, he indicated:

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101 Ibid paragraph 7.

102 Ibid paragraph 29 and 46.

103 Ibid paragraph 30.

104 Ibid paragraph 19 and 20.

- a. He had an issue with the person who wrote the TOPP<sup>105</sup> due to a statement he alleged she made about methadone patients at the Alcohol and Drug Service being, “*Look at those ratbags. The scum of the earth.*” He indicated he was of the view that this statement by the author was a reflection on the TOPP, and he never got over it.<sup>106</sup> Dr Jackson did not apply to call this witness to give evidence at inquest in order that he could challenge her motivation.
- b. That he believed the TOPP reflects an attitude of treating drug users as criminals, and that the way to have methadone accepted as a treatment was to view the drug addicted as criminals and treat them in a way which meant impacting their lives in a very restrictive coercive manner.<sup>107</sup>
- c. That he managed his patients partly in line with the TOPP but from his own knowledge and experience.<sup>108</sup>
- d. That there was a lot of criticism of the TOPP due to it being very rigid.<sup>109</sup>
- e. That he *totally disagreed* with the TOPP, particularly due to the views of its author.<sup>110</sup>
- f. That his view was that addiction is a chronic disease rather than an acute disease and no form of treatment will result in a cure.
- g. It is difficult to get patients into treatment and retain them in treatment; and that addicted patients are difficult because society has treated them badly. Because of this, there is a need to avoid regimented or dictatorial treatment as that approach would result in losing the patient.<sup>111</sup>
- h. That he was of the view that exiting a person from treatment was *immoral* and that by treating someone (even if they were not adhering to the program) he was reducing the death rate by 25% compared to if they were left without treatment.<sup>112</sup>

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105 It appeared that this person was assisting writing the guidelines.

106 T2364 line 15-40.

107 T2365 line 35 and 40.

108 T2373 line 15 – 35.

109 Ibid.

110 Ibid.

111 T2376.

112 T2382 paragraphs 5 – 15.

- i. That benzodiazepines were still the most effective treatment for anxiety disorders.<sup>113</sup>
- j. That 50% of people on the opioid pharmacotherapy program have an anxiety disorder and therefore need benzodiazepines. The long-term treatment of benzodiazepine dependence is to continue prescribing them.<sup>114</sup>
- k. That it is appropriate to continue benzodiazepines and prescribe opiate pharmacotherapy despite the sedating effect of the combination, as the person's tolerance to both drugs will reduce the sedative effect and they are more likely to die on the street than if they are on a program using both.<sup>115</sup>
- l. That, in terms of takeaway doses of methadone, his view is that needing to go to the pharmacy for each dose is an expensive and humiliating process and that if a patient is allowed to be normal and have their medication at home it helps the progress and treatment of the patient.<sup>116</sup>
- m. That, as a general rule, a practitioner would not prescribe takeaway doses to a patient. The correct practice is to start gradually, build trust and develop a relationship; and takeaway doses may be prescribed when the doctor judges it is safe. The move to prescribing takeaway doses is not black and white and it is a question of judgement gained with experience.<sup>117</sup> He said that, historically, takeaway doses were given even to initial patients due to pharmacies being closed on Sundays. Further takeaway doses were then determined by him based on stability of the patient.<sup>118</sup>
- n. That he would provide extra takeaway doses sometimes if the patient was unable to get to the pharmacy due to illness or personal reasons.<sup>119</sup>
- o. That he did not believe there was a need to require patients to come in for reviews before renewing opioid pharmacotherapy and

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113 T2383 paragraphs 5 – 15.

114 T2384.

115 T2387.

116 T2397.

117 T2398.

118 T2459 and T2460.

119 Ibid.

that he would leave it up to the patients as to whether they needed to see him, in which case he would.<sup>120</sup>

- p. That, when he initially assessed someone for methadone maintenance, he would look for needle marks but volunteered that he could not look at the groin for injection marks on a female patient unless she had a chaperone.<sup>121</sup>
- q. That the aim was never to get patients off methadone or to reduce the dose so that they were not using any opiates whatsoever.<sup>122</sup>
- r. That as a principle, he would never aim to reduce the dose except if the patient specifically asked.<sup>123</sup> He admitted that this principle was not accepted by others in the alcohol and drug field.
- s. That he did not see patients regularly due to his busy practice but would see them if they said they needed to. He was comfortable with this due to the fact that they were attending the pharmacy at least four times per week.<sup>124</sup>
- t. That he would ask a new patient what other drugs they were using but he assumed it was likely that they were using other substances and the main thing was to get them off the street opiate. When asked if he enquired about other substances to ensure they would not have a cumulative effect on the pharmacotherapy prescribed and were not contraindicated, he said that there were some things that you had to be incredibly careful with. He gave the example of grapefruit and a certain antibiotic, but gave no indication of consideration of the sedative effect on the CNS of opiates and other drugs such as benzodiazepines.<sup>125</sup> He did not check with patients what other drugs they may have been prescribed as he believed this was impractical.<sup>126</sup> Further, when renewing the opioid pharmacotherapy prescription he would not generally ask the patient if they were being prescribed any new medications.<sup>127</sup>

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120 T2405.

121 T2453.

122 T2468.

123 T2469.

124 T2473.

125 T2476 and 2T477.

126 *Ibid* page 2478.

127 *Ibid* page 2481 – 2482.

- u. That, in his view, only a small percentage of addicted people were at risk of abusing their medication. He said that this information was from research literature and his experience “*on a daily basis seeing these people.*”<sup>128</sup> He explained that a small percentage would have a personality disorder or major psychotic illness, but the average patient adequately treated on methadone is not drug seeking as their craving is obliterated by the methadone.<sup>129</sup>
- v. That, during his time practicing in addiction medicine, Dr Jackson admitted he had a number of disagreements regarding practice with other practitioners in the drug and alcohol field. These disagreements were mainly centred upon his prescribing practices in opioid pharmacotherapy dosage, co-prescription with other medications and takeaway doses. I accept the submission of counsel assisting that, when viewing the objective evidence, Dr Jackson significantly downplayed those disagreements and issues.<sup>130</sup>
- w. That he accepted, when assessing the suitability of a patient for pharmacotherapy treatment, the assessment should be directed to ascertaining the following:<sup>131</sup>
- The patient’s history of any lung or heart condition;
  - What substances, prescribed or unprescribed, the patient was using;
  - The patient’s family and social situation;
  - How long they had been engaging in use of opiates and other illicit drugs; and
  - Whether the patient was injecting drugs.
- x. He accepted the proposition that to find out the above information he would need to: ask the patient; obtain records from other treating practitioners; and conduct a physical examination and possibly a blood or urinalysis test.<sup>132</sup>
- y. He disagreed with the proposition put by counsel assisting that using

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128 T2484.

129 T2483 and 2484.

130 T2500 – 2515.

131 T2534.

132 Ibid.

other illicit substances was a sign that a patient was not stable; and said that this was *not* an indication of instability. He confirmed that use of other illicit substance was not a consideration of his when considering prescribing takeaway doses.<sup>133</sup>

- z. That use of benzodiazepines would only factor into consideration of takeaway doses if the patient was injecting illicit benzodiazepines (such as alprazolam) which could damage the lungs. In this case, Dr Jackson said that controlling the prescription of takeaway doses of methadone could be used as a “*bargaining chip for getting off the benzos.... intravenous benzos.*”<sup>134</sup>
- aa. That, in relation to the TOPP, he accepted its purpose was harm minimisation but did not accept the need for regular reviews or questioning regarding use of other drugs or illnesses and admitted much of the time he simply asked the patient generally how they were and renewed the script, expecting the patient or pharmacist would advise him if there was an issue.<sup>135</sup>
- bb. Confirmed he made little to no changes to his practice over time or as a result of the TOPP.<sup>136</sup>
- cc. Accepted, when put to him by counsel assisting, that prescription of pharmacotherapy requires:<sup>137</sup>
- Regular monitoring and follow up;
  - Assessment of patient stability on an ongoing basis;
  - Working collaboratively with others involved in the program (for example, pharmacists and psychologists);
  - Mitigating risk of overdose by ensuring stability before providing non-observed (takeaway) doses; and
  - Reducing or regulating the mixture of drugs and monitoring the mix (if there is one).

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133 T2543 – 2544.

134 T2544.

135 T2557 – 2559.

136 T2565.

137 T2565.

dd. Accepted that best practice of pharmacotherapy involves keeping good notes and records regarding consultations, prescriptions, takeaway doses and engagement with other providers in the program.<sup>138</sup>

ee. Confirmed he did not always keep records, explaining to the Court:

*“Oh well I mean the main reason for keeping those sort of records are are (sic) medicolegal reasons as in this instance. So that – so that um you you(sic) can er defend yourself. Um and I I suppose I was getting to an age where ah it didn’t worry me so much.”*

ff. He also added that he has a good memory and keeping notes would not have helped him at all in relation to tracking patients’ progress and providing them with consistent treatment.<sup>139</sup>

gg. He agreed in cross-examination that a very brief note made by him in respect of Ms Kemp<sup>140</sup> was a typical example of the way he made notes for his pharmacotherapy patients.<sup>141</sup> This note was in a Spirax notebook containing notes about various patients, often more than one patient per page.

hh. Dr Jackson sometimes included dates on his notes but did not always do so. Sometimes, the note contained a name only and other times a short note of a prescription. Routinely, his patient notes did not indicate the nature of the consultation, any history, the time or duration of the consultation, the reason for dose change or repeat prescription or any information regarding clinical stability.<sup>142</sup> Despite the difficulty reading and understanding his notes, there are clear examples where it is apparent he authorised takeaway doses in the face of obvious patient instability.<sup>143</sup>

ii. Dr Jackson said repeatedly in his evidence on the topic of notetaking, that the above mentioned notebook entries were actually “*running sheets*” and “*sort of on the spot aide-memoire*” written prior to more

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138 Transcript page 2566.

139 Ibid.

140 CNB10e at page 20.

141 T2608.

142 Transcript page 2599- 2602.

143 CBK10e – Takeaway doses authorised despite commencing Ms Kemp on Seroquel, a CNS depressant.

formal patient notes which he recorded on progress notepaper.<sup>144</sup>

Consistently with his evidence on this point, he suggested that his formal patient notes (which were not part of the evidence at inquest) were in existence but had not been seized by police. However, he was unable to produce any additional patient notes or provide any explanation as to why (when he knew his record keeping was an issue in the inquest) he had not provided them previously. Given the importance of such documents, if they existed, it would have been clearly in his interests to provide any additional patient records supporting his treatment of each deceased.

- jj. The fact that he has not provided them either before the inquest, during his evidence or since (nor did he mention them in his affidavit or when questioning Dr Brett) is strong evidence that no further patient notes exist. In addition, Dr Jackson plainly holds the view that maintaining medical notes is not a matter of substantive importance. I also observe that in terms of his prescribing practices, initial and ongoing assessments and keeping of records, that Dr Jackson's evidence in relation to the four deceased was largely consistent with that in his evidence regarding his general practice.<sup>145</sup>
- kk. For these reasons, I am positively satisfied that Dr Jackson did not have any additional formal system of note taking in respect of his pharmacotherapy patients. Given the ad hoc manner in which the notes were created and stored, it is possible that there exists other sundry notes made by Dr Jackson in respect of the four deceased. However, the police searches and recording of his exhibits have been careful and methodical. I am satisfied that there are no other patient notes in existence regarding the four deceased that would assist in the issues to be considered at inquest. I find that Dr Jackson was not truthful in asserting to the contrary and, in making such assertions, was unhelpful and misleading to the court in its task of inquiring into the four deaths.
- ll. In terms of the Salvation Army pharmacotherapy patients he was treating, Dr Jackson indicated he was of the understanding that Mr Jacometti would take a full history and then tell him what he needed to know or show him their files. However, he did not have access to the

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144 T2617.

145 The exception is in relation to Ms Wiki which will be discussed below.

Salvation Army information without going through Mr Jacometti.<sup>146</sup> If he needed to, he would take further information from the patient. He also gave evidence that he conducted an initial assessment and physical examination.<sup>147</sup>

- mm. He gave very confused evidence about whether he accessed, or had access to, Mr Jacometti's own notes or Salvation Army records, but he said he relied on Mr Jacometti to communicate to him. I formed the strong view that Dr Jackson did not refer to any notes, and that patient information in respect of the Salvation Army patients was conveyed to him orally by Mr Jacometti.<sup>148</sup>
- nn. That he would, after the first examination, sometimes rely upon Mr Jacometti's report on how the patient was going to prescribe further rather than see or speak to the patient himself.<sup>149</sup>
- oo. In relation to the important issue of the dangers of pharmacotherapy causing CNS depression, Dr Jackson refused to accept that opiates are CNS depressants.<sup>150</sup> He also did not accept that benzodiazepines are CNS depressants, at least that they may cause respiratory depression.<sup>151</sup> He said that he did not accept that opiates in combination with benzodiazepines increases CNS depression and risk of respiratory depression.<sup>152</sup>
- pp. Dr Jackson said that, in his view, if a person requests continuation of high doses of benzodiazepines, this should be provided, and that it is a futile exercise to attempt to reduce and cease benzodiazepines if they are dependent on them.<sup>153</sup> He did not accept that higher than 5mg doses of a benzodiazepine should not be prescribed with opioid pharmacotherapy and does not follow that direction as provided by the TOPP.<sup>154</sup>
- qq. In evidence, Dr Jackson agreed that he did not necessarily obtain

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146 T2573.

147 T2578.

148 T2577.

149 T2593.

150 T2528.

151 T2545.

152 T2545-2457 and T2562-3.

153 T2548.

154 T2562 and TOPP section 8.6.2.

authorities for prescribing Schedule 8 drugs.<sup>155</sup> He believed that PSB sent information not only to pharmacies and medical practitioners but to police when applications came in - and therefore everyone knew the person was “a junkie”.<sup>156</sup> He believed it a formal policy of hospitals to treat those whose files indicated drug dependence last despite their ailment. He suggested that Ms Kemp would have been made to wait hours for pneumonia treatment due to her being flagged as drug dependent.<sup>157</sup>

- rr. His practice regarding takeaway doses was initially not to prescribe but to give short prescriptions of pharmacy dosing and then review. However, after that initial period he would assess and provide what he thought appropriate.<sup>158</sup> However, the evidence in the inquest, particularly regarding three of the deceased, suggests that Dr Jackson did prescribe initial takeaway doses as well as continued and increased takeaway doses without review and ensuring ongoing clinical stability.
- ss. Further, Dr Jackson’s process of reviewing was *ad hoc* and would often depend on whether they made an appointment and the length of the prescription.<sup>159</sup>

170. Having set out his evidence, a final point to be made regarding Dr Jackson’s attitude towards pharmacotherapy and his prescribing practices relates to his behaviour following Mr Brown’s death.

171. Mr Winwood died on 4 August 2017, ten months after Mr Brown, five months after Ms Wiki and one month after Ms Kemp. On 16 August 2017, the Coroner’s Associate sent a letter to the Hobart Clinic to obtain a copy of all of Mr Winwood’s medical records. Again, Dr Jackson failed to respond to the Coroner’s Associate’s request. Mr Winwood’s patient notes were subsequently seized by police during the previously mentioned search on 27 December 2017. A copy of this letter was located by police within Mr Winwood’s patient file along with Mr Winwood’s death notice from the Mercury Newspaper dated 7 August 2017.

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155 T2536 – 2539.

156 T2581.

157 T2585

158 T2540-2542.

159 T2540-1.

172. Throughout the period of the deaths of his patients, and even despite receiving a notice from AHPRA in April 2017, Dr Jackson's same prescribing practices continued without modification. Primarily, these were the prescribing of high numbers of takeaway doses, minimal or no clinical reviews or examinations of patients, and co-prescribing benzodiazepines with Schedule 8 medications.
173. In broad terms, and in accordance with the scope, the issue at inquest was whether Dr Jackson inappropriately prescribed methadone, benzodiazepines and other drugs, to the four deceased; and if so, whether that prescribing caused or contributed to or was part of the circumstances surrounding one or more of the deaths. Thus, the inquest focused significantly upon the cause of death and whether Dr Jackson had departed from appropriate treating and prescribing practices, particularly as set out in the TOPP guidelines.

#### Dr Jackson's points of contention

174. In his closing submissions, the main points of contention raised by Dr Jackson were as follows:
1. At all material times, he was motivated by a desire to help people suffering from the scourge of illicit drug use and drug addiction:
    - Who would otherwise face difficulty in sourcing any treatment at all, given the strains on the alcohol and drug treatment system at the time, and the inability to get patients into the Alcohol and Drug Service or once in, maintaining them as patients;
    - When they faced the unwillingness of general practitioners to be involved in treatment of people with drug addiction; and
    - When many practitioners perceived, including Dr Jackson, that the TOPP was excessively restrictive, overly prescriptive, convoluted, and unclear, compared to other Australian guidelines.
  2. That the TOPP was purely a guide, was overly restrictive, was "*completely out of date*" and was not useful for everyday practice.<sup>160</sup> He considered that many other practitioners were of the same view and departed from the guidelines, particularly when they restricted their clinical judgement and the autonomy of patients.

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<sup>160</sup> Closing submissions at paragraph 4.

3. The toxicological results for each of the deceased indicating the presence of methadone in the postmortem blood samples must be regarded with significant caution for two reasons. Firstly, the specified methadone levels referred to in the toxicology reports are not an accurate reflection of the probable level ingested before death due to the phenomenon of postmortem redistribution. Secondly, the issue of tolerance with repeated use of methadone means that an appropriately prescribed dose for a tolerant individual might greatly exceed the reported therapeutic range. In other words, a tolerant individual may exhibit few signs of impairment with a drug level which might be considered toxic to an intolerant individual.
4. The death of Ms Wiki involved a cardiac arrest due to the injection into her neck of illicitly sourced crushed insoluble alprazolam tablets. This act of injection caused blockages to blood vessels, most critically to her heart. As such, Dr Jackson submitted that there was no evidence of a direct nexus between her death and the prescription or misuse of methadone or any other drug prescribed by him. Further, there is no evidence that Ms Wiki's use of methadone, including takeaway doses in the prescribing of benzodiazepines to her, and her use of those had any relevant causal connection with her death. Therefore, it is submitted, the Coroner does not have jurisdiction to make comment, or recommendations regarding criticism of Dr Jackson's prescribing of methadone and benzodiazepines.
5. In relation to the death of Ms Kemp, Dr Jackson contended that she died as a result of community acquired pneumonia following an upper respiratory tract infection. Dr Jackson submitted that his prescribing of methadone and other prescription medications to Ms Kemp was regular and had been unchanged for many years prior to her death. Further, he said he had acted reasonably in prescribing Ms Kemp antibiotics for her infection in mid-June, three weeks before her death and expected her to fill the prescription.<sup>161</sup> It was also reasonable for Ms Kemp at that point to continue with her usual methadone and other medications. This being the case, Dr Jackson submitted that there is no causal connection between his actions and the death of Ms Kemp.
6. In relation to Mr Winwood, Dr Jackson submitted that drug toxicity as a

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<sup>161</sup> Prescribed 14 June 2017, filled script 22 June 2017, died 6 July 2017.

contribution to cause of death was unlikely, that the treatment regime had been long-standing and without evidence of prior overdose or toxicity. He submitted that the expert evidence pointed to positional asphyxia caused by Mr Winwood experiencing an alcohol withdrawal seizure and collapse, together with significant heart and lung disease. As it was unlikely that Mr Winwood died of drug toxicity, there was no sufficient causal nexus to make comment on any alleged failure or departure from appropriate care by him.

7. In relation to Mr Brown, Dr Jackson accepted that, upon the evidence at inquest, Mr Brown lied to him to obtain prescriptions for methadone, including additional takeaway doses and that he acted on those lies to provide Mr Brown with prescriptions of methadone. However, Dr Jackson submitted that there was insufficient evidence to establish if the methadone or other prescription medication ingested by Mr Brown leading to his death, was that prescribed by Dr Jackson or other methadone obtained illicitly or from his partner (who may have tampered with the scene by hiding her medication). Dr Jackson also stated that he attempted to establish the treatment regime for Mr Brown through prison authorities but was unable to get the information.

### *Salvation Army*

175. The Salvation Army is an international Christian church, and registered charity operating on a global basis. It is one of Australia's largest providers of alcohol and drug services. Across the country, it offers a range of programs including withdrawal management, residential rehabilitation, non-residential rehabilitation, community programs and harm reduction services.<sup>162</sup>
176. The Salvation Army has operated Alcohol and Other Drugs programs in Tasmania since 1986, and continues to operate the Bridge Program in Hobart. Its premises are situated in New Town and have been since 1995.<sup>163</sup>
177. The court was assisted by the evidence of Penelope Chugg who was, at the time she gave evidence at inquest, the Statewide Manager for the Salvation Army Alcohol and Other Drugs Program in Tasmania and was also the National

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<sup>162</sup> Salvation Army Website.

<sup>163</sup> Ibid.

Project Manager for the National Program.<sup>164</sup> She had been the Statewide Manager since 2018 but had worked in the Alcohol and Drug Program (the Bridge Program) since 2011. Ms Chugg was well qualified to hold this position and provide such evidence, which is summarised below.<sup>165</sup>

178. The Bridge Program in Hobart is an alcohol and drug treatment program which runs various programs including harm reduction, needle and syringe, and diversion. This includes case managing patients and includes one-on-one counselling, day programs, a residential program and a home-based withdrawal program and ongoing after care. The program generally utilises the services of professionals - including clinical psychologists, counsellors, social workers and other practitioners who provide a range of support options. These professionals are required to comply with their own specific standards of practice.<sup>166</sup>
179. In her affidavit, annexing the Salvation Army Alcohol and Other Drug Services National Model of Care document, Ms Chugg explained that the Salvation Army aims to base its programs on a model of “*person-centered*” care, where participants have the right to choice, and treatment is tailored and individualised. She said that the Salvation Army operates under a harm reduction framework that does not condone substance abuse but acknowledges that some people will use alcohol and drugs. The service encourages choice and believes in the capacity of people to guide their own treatment pathways with a health-focused approach.<sup>167</sup>
180. The Salvation Army held files for Mr Brown, Mr Winwood and Ms Kemp at the Hobart Bridge Program which were taken by Tasmania Police on 28 December 2017.<sup>168</sup> Each had participated in the non-residential and/or residential withdrawal program.
181. Ms Chugg said in her affidavit that the Salvation Army did not employ Dr Jackson. In fact, Dr Jackson provided pharmacotherapy medical services at a room allocated to him by the Salvation Army in the Bridge Centre premises. It

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164 Ms Chugg gave her evidence in the form of three affidavits dated 9 February 2018 (NB29), 25 May 2020 (NB 30) and 12 September 2022 (G30). The affidavit G30 also had a number of annexures. Ms Chugg gave evidence orally at the inquest and was cross examined, this evidence is at T1765-1817.

165 Her qualifications include a business degree and a graduate certificate in business management and diplomas in community services, mental health, alcohol and other drugs, and neuroscience leadership: T1766.

166 G30 paragraph 19.

167 G30.

168 NB 29 Affidavit of Penelope Chugg 9 February 2018 paragraph 11.

was understood that he would provide those services to some of the Salvation Army clients as well as his own clients. It is unclear what proportion of his clients were private, and which were referrals.

182. There was no supervision of Dr Jackson by the Salvation Army when he worked at its premises. However, Ms Chugg believed Dr Jackson was well regarded given his previous experience as Director of ADS and she said that he had an excellent reputation. She described the Salvation Army's role in the pharmacotherapy program as providing a room for Dr Jackson with Mr Jacometti as support and liaison between Dr Jackson and the patient.
183. Ms Chugg gave unchallenged evidence that the model of care involving an external specialist provider working at Salvation Army premises, partly servicing Salvation Army clients, was one which was widespread throughout the organisation. In such a situation, doctors or other specialists are provided simply with a room and are responsible for their own provision of service with no oversight by the Salvation Army. In the case of Dr Jackson, the Salvation Army did not store his patient records or even have access to them.
184. The Salvation Army was aware that Dr Jackson also serviced his own clients, particularly from the Hobart Clinic. The Salvation Army was also aware that its employed registered nurse, Mr Jacometti, organised appointments and conducted follow-up case management for patients after they had seen Dr Jackson.
185. Ms Chugg confirmed Mr Jacometti's role as an employed home-based withdrawal nurse providing mental health support to clients of the program and administrative support. She said that he was also a liaison for Dr Jackson. She further outlined that he primarily undertook such a liaison role by relaying information between Dr Jackson and his patients.<sup>169</sup>
186. Ms Chugg went on to say that the work with Dr Jackson and his patients was "*off the side*" of his desk and his designated role was as the home-based withdrawal nurse to support people who wanted to withdraw from drugs or alcohol. However, she said that as the home-based withdrawal work diminished, the bulk of Mr Jacometti's work was as a mental health nurse in which role he mainly trained staff and worked with clinical psychologists to ensure that the mental health needs of the clients were being met.<sup>170</sup> She said

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169 NB29.

170 T1769.

his role was approximately 80% mental health nurse and 20% home-based withdrawal.

187. Ms Chugg emphasised that his work with pharmacotherapy clients was totally separate to the home-based withdrawal role. The role, she said, was outside his job description but he nevertheless took it on. There is no evidence that the Salvation Army objected to Mr Jacometti working in this capacity with Dr Jackson, even though it was initiated by Mr Jacometti himself. In fact, this aspect of his role was positively supported by the Salvation Army, perhaps because his work in home-based withdrawal had reduced significantly as client complexities grew with less clients able to safely complete this program.<sup>171</sup>
188. Ms Chugg reviewed retrospectively the notes made by Mr Jacometti and commented in evidence that they “*do leave a little bit to be desired.*”<sup>172</sup> She went on to indicate that she researched and authored a case note framework in 2018 to set standards and guidelines for making case notes. She explained that there was previously no guidance or framework for record or note keeping (including at the time relevant to this inquest).
189. She described the difficulties in recording detailed sensitive information with respect to the *Privacy Act* and said that, before writing the framework in her national role, she had been very concerned about the standard of case notes and how case notes should be made by a “*community service type organisation*”.<sup>173</sup>
190. In this inquest, there can be no suggestion that any decisions, actions or omissions of the Salvation Army played any role in the deaths. However, the inquest properly examined any systems issues that may have allowed the Salvation Army to be more accountable generally for mutual patients receiving pharmacotherapy; and to explore whether there were any missed opportunities to become aware of Dr Jackson’s anomalous prescribing practices. This is especially the case as the Salvation Army knew that its employee was undertaking, at the very least, a liaison role outside his job description for Dr Jackson and that he did not have addiction qualifications.
191. Therefore, in this regard, the inquest examined Dr Jackson’s working arrangements, Mr Jacometti’s working arrangements and supervision, patient

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171 T1796-7.

172 T1776.

173 T1775.

record-keeping and adequacy of information sharing, particularly as it pertained to Mr Brown, Mr Winwood and Ms Kemp who were participants in a Salvation Army Program.

#### Salvation Army points of contention

192. The Salvation Army, seeking to distance itself from the actions of Dr Jackson, responsibility and adverse comment, raised the following matters:

- That it had no reason to suspect any significant deviation by Dr Jackson, breach of authority or occurrence of irregularities. There had never been a complaint about him and he was qualified in addiction medicine. Further, his presence potentially solved long wait times for pharmacotherapy. This, in turn, reduced the risk of deaths by overdose while patients are waiting for treatment.
- That the model of providing a room to a medical professional or external service provider for mutual benefit but with no oversight by the Salvation Army was a widespread approach which worked very well.<sup>174</sup> It constituted a “*wrap around holistic approach*” for clients.<sup>175</sup>
- That there was no legal relationship between Salvation Army and Dr Jackson.
- That the TOPP guidelines do not provide client-based care as they are overly restrictive.
- That employee, Mr Jacometti, was only a conduit or filter for Dr Jackson - not in a partnership and in a lesser role.
- That Mr Jacometti’s records were lacking but the Salvation Army assumed, not unreasonably, that Dr Jackson kept his own patient records.
- Dr Jackson did not at any time request Salvation Army records of any patients.

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174 T1767.

175 T1767 and 1768.

*Nicolaas Jacometti*

193. Mr Jacometti was born on 13 March 1954 and, at all material times resided in Tasmania. He graduated as a registered nurse in 1982 after completing his studies in New Zealand. In 1994 he obtained a diploma of occupational health practice in New Zealand. From 1997 to 2001, he worked as a registered nurse at the RHH and between 2001 and 2007 he worked as a nurse and then health and hygiene advisor at the Zinifex Hobart Smelter. In 2007 he returned to work in acute care clinical nursing at the RHH.
194. From about 2011, he was employed by the Salvation Army as a home-based withdrawal nurse and worked in this role until March 2017. Subsequently, he continued working two days per week whilst the Salvation Army was recruiting a nurse. Due to this process not being successful, he continued to work two days per week until his resignation in May 2018.<sup>176</sup> Mr Jacometti is now retired.<sup>177</sup>
195. Mr Jacometti was the only employee of the Salvation Army dealing with pharmacotherapy. Ms Chugg gave evidence of the process in the program for referrals of Salvation Army clients to pharmacotherapy. She said that a supervisor, or "*Clinical Lead*" within the organisation would identify eligibility for a Salvation Army program generally and if that person appeared to be suitable for pharmacotherapy, the supervisor would contact the nurse, being Mr Jacometti. The process then involved Mr Jacometti arranging for them to see Dr Jackson.<sup>178</sup>
196. Ms Chugg gave evidence that Mr Jacometti then conducted his own assessment and referred to Dr Jackson or another service who provided pharmacotherapy such as ADS. She said that the client was given the choice of service. She was firm in her evidence that this initial assessment by Mr Jacometti was done not in his capacity as a nurse but with his knowledge about eligibility criteria for the pharmacology program.<sup>179</sup>
197. Mr Jacometti told the court that he had no qualifications, training or experience in pharmacotherapy before he began working with Dr Jackson, though he did

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176 NB29 paragraph 2; T1765-1766.

177 T2143.

178 T1790-1791.

179 T1791.

have experience working with people with addictions in the home-based withdrawal program.<sup>180</sup>

198. He did not, however, accept after significant questioning that, on his own, he was not qualified to make an assessment as to whether someone is suitable to enter the pharmacotherapy program.<sup>181</sup> He agreed that he acted as a conduit or filter for Dr Jackson so that he did not get overwhelmed with too many requests; and he would then pass on information to him by text, phone or fax.<sup>182</sup>
199. Mr Jacometti gave oral evidence to the inquest on 25 May 2023.<sup>183</sup> He also provided affidavits dated 27 March 2017<sup>184</sup> and 12 September 2022,<sup>185</sup> and participated in interviews with officers of Tasmania Police under caution conducted on 21 and 22 November 2019.<sup>186</sup>
200. The need for Mr Jacometti to be interviewed under caution related to his alleged role in providing police with a suspected false pharmacotherapy record of Mr Brown's methadone prescribing and dispensing just before his death. Mr Jacometti provided to police a spreadsheet dated 28 September 2016 used by him to record patient names and medication. On that spreadsheet, the name *Nicholas Brown* is recorded as a patient being given 32mg Subutex and in prison. Mr Jacometti subsequently provided police with another, undated, spreadsheet which had been edited. The handwritten words "*methadone 60mg*" was written over the word *Subutex 32mg* which had been erased with whiteout. The word "*prison*" also erased with whiteout.<sup>187</sup>
201. Mr Jacometti attempted to explain at inquest the changes made to the spreadsheet but, as submitted by counsel assisting, could not do so credibly.<sup>188</sup> It would seem that the rational reason for the change was to conceal the fact that he and/or Dr Jackson were aware that the spreadsheet contained evidence that Mr Brown was being prescribed Subutex in prison and not methadone as Mr Brown later claimed. However, bearing in mind the standard of proof for a finding of dishonesty or intention to mislead an investigation, I do not make such a positive finding.

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180 T2180-82.

181 T2186-88.

182 T2153.

183 T2143-2277.

184 NB15.

185 G5-4.

186 N16a and b.

187 NB15 pages 4-6.

188 T2271-2.

202. From the outset, I had significant concerns about his role in actively facilitating provision to Mr Brown of potentially fatal takeaway doses of methadone. The investigation of this issue led to further concerns about the role of Mr Jacometti in his partnership with Dr Jackson.
203. Therefore, it has been necessary to critically examine Mr Jacometti's role generally, the nature of his duties, and his relationship with Dr Jackson. Over the years of this investigation, the evidence gathered suggested that Dr Jackson and Mr Jacometti, together, were delivering pharmacotherapy services to patients in a manner that was well outside the TOPP guidelines, and were both adherents to an approach to OST involving liberal supply of takeaway doses to patients upon their request, regardless of objective risk.
204. For the reasons given, it is critical to understand Mr Jacometti's practice and motivation, notwithstanding that he was qualified only as a nurse and unable to prescribe opioids or opioid replacement medication.
205. In his evidence, Mr Jacometti indicated that as at 2017 he had worked with Dr Jackson in for five years. During this period, he would have a weekly meeting with Dr Jackson at Salvation Army Bridge Centre to discuss pharmacotherapy patients and their medication requirements. He said as at 2017 they managed about 25 pharmacotherapy clients together at the Bridge Program.<sup>189</sup>
206. Counsel assisting provided a comprehensive summary of Mr Jacometti's evidence in their closing submissions. Below, I set out the main evidence of Mr Jacometti relevant to the issues in this inquest. The following summary largely follows the helpful analysis by counsel assisting.
207. I set out below the pertinent points of Mr Jacometti's evidence as follows.<sup>187</sup>
- Mr Jacometti acknowledged that under the TOPP guidelines there was a maximum permitted number of three takeaway doses weekly. However, he said this was on a case-by-case basis and he and Dr Jackson would review the patient's requirement for takeaway doses. He gave evidence that four weekly takeaway doses was the maximum number discussed.<sup>190</sup>
  - He acknowledged that the TOPP specified that there should be no take-

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189 NB15 page 2.

190 Ibid. and NB15 at page 15.

away doses for 6 months and then at the discretion of the practitioner conducting the urine or drug testing. However, his evidence suggested that such guidelines regarding takeaway doses were more applicable to ORT delivered at ADS.<sup>191</sup>

- He said that they built relationships with pharmacotherapy clients based on trust so that their needs were fulfilled. This approach, in turn, assisted with stability. He stated that at the Bridge Program urine testing did not occur to the extent it did with ADS.<sup>192</sup> In his evidence at inquest, he went further and told the court that they did not conduct urine testing because even if it was a positive result, he would not deny service to the patient (being prescription of opioid pharmacotherapy).<sup>193</sup>
- He said in evidence at inquest that he and Dr Jackson were aware that there was a difference in how they dealt with their clients as opposed to ADS and that they tended to “*believe our clients a bit more.*”<sup>194</sup>
- Mr Jacometti’s understanding was that the TOPP was used by private prescribers as a guideline and not a regulation and that the prescribing of takeaway doses was at the discretion of the prescriber who may then have to justify it to PSB.<sup>195</sup> When asked in his interview what private providers of pharmacotherapy refer to in order to guide prescribing, he indicated that they referred to the National Guidelines. However, when asked about the contents of these guidelines, he said he knew they existed as the document was on his desk and it was a reference manual. However, he was unable to recall any content.<sup>196</sup>
- He indicated he was not certain as to the requirements under the TOPP, explaining in a police interview “*I didn’t work for the Government, I wasn’t a State employee, so the TOPP was not my working document you know. My working document was the relationship with Doctor Jackson and his, his practice.*”<sup>197</sup>

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191 Nb16a Interview page 8.

192 Nb 15 page 2.

193 T2146.

194 T2145.

195 NB16a at page 47.

196 NB16b at page 5.

197 NB16a at page 50.

- His understanding of the goal of he and Dr Jackson was to provide medication to stabilise the client, then reduce their dependence on the opioid substitution.<sup>198</sup>
- He recognised the potential issue with some unstable ORT patients for diversion drugs and sourcing additional illicit substances.<sup>199</sup>
- He indicated that Dr Jackson did allow takeaway doses above those provided for by the TOPP but also indicated there were times he would refuse extra takeaways or dose changes when requested by a patient.<sup>200</sup> However, there is no evidence to support this assertion in notes, email, phone or text conversations.
- Mr Jacometti was questioned about the interactions between methadone and benzodiazepines. He indicated that he understood they were both depressants, stating in his interview:

*“..they potentiate each other, they’re both depressants, serial depressants, so they potentiate each other and you mentioned about respiratory depression, you know you’re just slowing up, um and that’s true. You know that’s something that you have to watch out for.”<sup>201</sup>*

He said that sometimes clients who had been taking “a cocktail of drugs” for some time would develop a tolerance to them. He also indicated that with drug addiction:

*“...you are not just dealing with drug addiction but mental health issues... and high levels of anxiety. They have been taking drugs for some time and they are their go-to things. They know how to hunt, where to get them....to get pills if they want.”<sup>202</sup>*

- He acknowledged that the TOPP recommends benzodiazepines not be prescribed long term; and he agreed that people should not be taking a benzodiazepine for months or years on end, that it does not work and is

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198 T2147.

199 T2169.

200 NB16b page 94-5.

201 NB16a page 15.

202 NB16a page 16.

a terrible drug.<sup>203</sup>

- Mr Jacometti said that, upon the patient being referred, there was an initial appointment between the patient and himself. He indicated that patient health information would be recorded at this initial meeting on forms provided by Salvation Army which would then be stored within the Salvation Army Record keeping.<sup>204</sup> However, when pressed, he said he did not recall seeing or providing those forms in relation to Mr Brown, Ms Kemp or any pharmacotherapy patient, nor providing those forms to Dr Jackson.<sup>205</sup>
- Mr Jacometti said that when, subsequently, Dr Jackson saw the patients for the first time, he (Mr Jacometti) would also be in the meeting.<sup>206</sup> The meeting would be conversational with some questions about their health. He said that (clinical) observations or blood screening would not be done at the initial meeting but he did “obs” at other meetings.<sup>207</sup>
- Mr Jacometti said that at this meeting that Dr Jackson would not always ask about their social situation, but this was something that Mr Jacometti asked at the initial appointment. However, when pressed he said he did not always pass that information on to Dr Jackson and there was no plan or protocol for doing so. He said Dr Jackson would generally ask about their physical health and medical history, including cardiac and respiratory, but he did not recall Dr Jackson ever conducting any physical examinations or seeking permission to access medical and prescribing history from other treating physicians. There was no initial urinalysis, and they would simply accept the patient’s own report of what drugs they were using, prescribed or unprescribed. The reason he gave for not conducting such baseline tests was “*because we wanted to believe what they had to say*”.<sup>208</sup>
- In his interview he said that the physical condition of the patient was checked at the assessment. This was somewhat at odds with his other evidence that observations were not done at the initial meeting. He said

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203 NB16a page 17.

204 T2191-2192.

205 T2192-2195.

206 NB16a page 18-20 and T2198.

207 NB16b page 19 – 21.

208 T2199-2201.

that the physical checks would be done “*if it was indicated*”<sup>209</sup> and went on to explain that this would generally mean if he noticed some significant physical change such as significant weight loss. He said that he would check for injection sites but was unable to indicate how often.<sup>210</sup> Mr Jacometti said he would sometimes do home visit welfare checks upon patients but during those checks physical examinations did not routinely occur as his role was talking to them.<sup>211</sup>

- Contrary to the evidence of Ms Chugg, Mr Jacometti told the court that he was practicing as a nurse in the dealings with patients he saw for pharmacotherapy treatment with Dr Jackson.<sup>212</sup> However he indicated he did not conduct physical examinations, could not recall ever taking the blood pressure of a pharmacotherapy patient or obtaining their medical histories.<sup>213</sup> He said his main involvement with pharmacotherapy patients was meeting with them, speaking with them and passing their needs or wants on to Dr Jackson.<sup>214</sup> He accepted that he was not qualified to conduct reviews of patients already on the program.<sup>215</sup>
- He accepted the drugs prescribed in opioid pharmacotherapy were central nervous system depressants. He said that he would ask a patient at the initial meeting with them, whether they had any respiratory or cardiac conditions but he did not conduct further investigations into this as he was of the view this was the role of the prescribing doctor.<sup>216</sup>
- He suggested that they would check a patient’s physical and mental status to establish stability and they usually did two urine drug screens on each patient but did not do any more as they didn’t see a useful purpose to it.<sup>217</sup>
- He said he and Dr Jackson documented their meetings with pharmacotherapy patients “*to some degree or just a note.*”<sup>218</sup> He

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209 T2455.

210 NB16b page 32-38.

211 NB16b page 78-9.

212 T2169.

213 T2180.

214 Ibid.

215 T2188.

216 T2190.

217 NB16b page 35-6.

218 NB16a page 18-20.

agreed that the meetings were documented poorly by both he and Dr Jackson.<sup>219</sup> He admitted his note-keeping could have been better and confirmed there was no reporting he was required to do for the Salvation Army to account for his hours at work or to supervisors.<sup>220</sup>

- He agreed he communicated with clients about new scripts and takeaways and then would sometimes text Dr Jackson regarding what the clients were requesting. He acknowledged he was a go-between for the patients and Dr Jackson.<sup>221</sup>
- He admitted it could be difficult to “*verify the request*” (for medication or takeaways) saying that “*there is a risk there of course that they are telling lies, cause they do*”. He went on to say that it is difficult to say no but sometimes they have to, due to it (the medication or take aways) being deemed as not safe. However, he said they get a measure of understanding of a particular client when it is a relationship that has built up and there is a level of trust.<sup>222</sup>
- Mr Jacometti was presented with a spreadsheet in his police interview and in his evidence and accepted it was created by him. This spreadsheet contained names and contact details of patients, what they were prescribed (opioid pharmacotherapy only), the pharmacy at which they received their pharmacotherapy medication and the next date their prescription expired. He indicated they were the patients with whom he had dealings.<sup>223</sup>
- He acknowledged that under the TOPP, a compromised respiratory system would be an indicator that a reassessment should occur in a person prescribed pharmacotherapy.<sup>224</sup>
- He gave confused answers at interview regarding how the process of Schedule 8 authorities occurred. I agree with the submissions of counsel assisting that his answers revealed a fundamental lack of understanding of the process of gaining a Schedule 8 authority on behalf of a patient. However, as with the majority of his evidence, he returned to justifying his

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219 NB16b page 22-3.

220 NB16a page 66.

221 NB16a page 22 and 71; ExNB16b page 80-81.

222 NB16a page 22.

223 NB16a page 59-62.

224 NB16a page 70.

lack of knowledge on the basis that, as prescriber, Dr Jackson had the ultimate responsibility in this regard.<sup>225</sup>

- In his police interview, Mr Jacometti unequivocally told the interviewing officers that prescriptions were written in front of patients so they knew what had been prescribed.<sup>226</sup> He later in evidence at the inquest indicated there were many occasions when prescriptions were written for patients who had requested them (usually repeats) over the phone or by text or email. They were then faxed to the pharmacy by Dr Jackson or Mr Jacometti without the patient seeing them.<sup>227</sup>
- When looking at the spreadsheet of pharmacotherapy patients, he indicated that his estimate would be that 75% would be stable with low risk. He then said that of the 26 patients, half would be stable, and the other half would be of moderate risk. It appears from his evidence that he considered the “moderate risk” patients were at risk of deviating from their medication regime and/or sourcing other substances.<sup>228</sup>
- At inquest, he initially denied having asked Dr Jackson to prescribe to patients without seeing them. However, he was shown exhibit NB65a, relating to Mr Brown and another patient. This was an email from himself to Dr Jackson, commencing with the words:

*“Hi David, need a couple of verbal orders for some diazepam for two new clients in the rehab program, also I would like you to see them if it is possible on Wednesday or Thursday.”*

He then gave brief details of the patients and the reason for the requests. He admitted that in relation to Mr Brown, he asked Dr Jackson to prescribe a benzodiazepine without Dr Jackson having ever met him. He admitted he did so without seeking any respiratory or cardiac history or conducting any physical examinations or assessments. He also confirmed that Dr Jackson did not ask for any information or history or ask Mr Jacometti to conduct any examinations or assessments.<sup>229</sup>

- Mr Jacometti said that once patients initially started on the

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225 NB16a at page 71-72.

226 NB16b at page 27.

227 T2259.

228 T2174.

229 T2196-7.

pharmacotherapy program, they were only given short-dated scripts of about two weeks<sup>230</sup>. However, he was evasive in his evidence concerning the length of the initial script given to Mr Brown. He later indicated the initial script was for one month with one takeaway dose and then two months with one takeaway dose.<sup>231</sup>

- When asked, he said he was unaware of the requirement of the Schedule 8 authority imposing a requirement that there be no takeaway doses prescribed for the first three months on pharmacotherapy. His evidence did not convey that he had seen any Schedule 8 documents, nor was he familiar with their contents. However, as referred to earlier, he was aware of this recommendation under the TOPP, as well as the requirement that patients on pharmacotherapy be prescribed no more than 5mg of benzodiazepines per day.<sup>232</sup> He confirmed he understood the dangers of mixing opioids and benzodiazepines. However, he had no recollection of ever discussing the risk issues regarding prescription of benzodiazepines or takeaway doses with Dr Jackson.<sup>233</sup>
- In terms of reviewing pharmacotherapy patients, he indicated that patient reviews were done predominantly with Dr Jackson and some by himself. It was put to him by counsel assisting that most reviews of at least Mr Brown and Ms Kemp were done by Mr Jacometti alone. He did not accept this but the notes of Dr Jackson bear this out.
- In terms of the substance of the reviews, Mr Jacometti indicated discussions would occur with the patients regarding whether the medication was achieving the desired outcome in that they weren't experiencing withdrawal symptoms and whether they were using other unprescribed substances (though this wasn't asked every time). He said that they would review both the opioid and any other medication prescribed by Dr Jackson. He could not recall any discussions with the patients about reduction of either opioid or other medications prescribed or whether they were injecting. As mentioned previously, there was no urinalysis undertaken. Patients were only occasionally checked for needle marks and he could not recall Mr Brown or Ms Kemp ever being

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230 T2203-2210.

231 T2210.

232 T2210-2212.

233 T2210-2214.

checked for injection sites.<sup>234</sup>

- He stated he understood the importance of reviewing patients to determine their stability and understood what needed to be considered including use of other substances, injecting, changes in social situation, health, their history, their time in pharmacotherapy, compliance in attending reviews. However, he admitted there was nothing in place to ensure regular review other than relying on clients to make their own appointment if they deemed necessary or when their prescriptions expired.<sup>235</sup>
- He admitted, after being taken through numerous instances, to it not being unusual for a patient to contact him and indicate their script had run out, that they required different medication or takeaway doses, and he would then pass that on to Dr Jackson who would write the prescription or authorise the takeaway doses without any further enquiry, assessment or review.<sup>236</sup>
- In relation to takeaway doses, Mr Jacometti admitted he would often receive contact from patients requesting an increase in their takeaway dose for various reasons. He admitted he did nothing to further assess or confirm their stability before sending the request to Dr Jackson and that Dr Jackson did not ask Mr Jacometti any questions relating to the stability of the patient.<sup>237</sup>

#### General comments about Mr Jacometti's evidence

208. General comments should be made about Mr Jacometti's evidence and his involvement in pharmacotherapy with Dr Jackson.
209. Mr Jacometti's role in the circumstances of Mr Brown receiving takeaway methadone doses requires separate and careful scrutiny; in particular, whether his actions with were contributory to or connected with Mr Brown's death. This specific matter will be dealt with when discussing the circumstances of Mr Brown's death. However, the evidence of Mr Jacometti is highly relevant to understand his approach and motivation, as well as his departures from recognised standards of care in treatment of patients on ORT.

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234 T2205-7.

235 T2207-2211.

236 T2219.

237 T2231-2232

210. Having considered the large quantity of his evidence from various sources, I find that Mr Jacometti was not sufficiently familiar with, or qualified in, opioid pharmacotherapy to competently manage a complex cohort of patients such as those at the Bridge Program. Moreover, he did not engage in ongoing education, advice or support -a part from any learnings from Dr Jackson. The proposal to work with Dr Jackson was beyond his skills and training. Mr Jacometti did not appear to have a desire to develop skills in this area as a registered nurse might (or should) seek to do. He offered little by way of clinical support to patients, being effectively no more than a conduit for communications between patients and Dr Jackson.
211. He was aware in general terms that ORT was attended with risk, and yet he did not engage in or even suggest to Dr Jackson additional practices that would ameliorate those risks. I would have expected a registered nurse, from basic training alone, to have conducted more rigorous physical health checks, assess clinical stability for the purpose of ORT at regular intervals, document the meetings and appointments so that the patients' clinical trajectory could be properly monitored; and seek directions from and have discussions with the supervising medical practitioner regarding the patients and their continuing suitability for takeaway doses.
212. To say, as he did repetitively, that Dr Jackson bore the responsibility for the patients is understandable and mainly true. But it does not address Mr Jacometti's significant lack of knowledge of ORT, Schedule 8 authorities and TOPP; and why as a registered nurse he did not seek to question Dr Jackson's decisions.
213. Counsel assisting concisely submitted in closing submissions:
- "Mr Jacometti was aware of the need to ensure stability in patients before prescribing takeaway doses and also the danger of combining benzos [benzodiazepines] in terms of CNS depression. Yet he went along with Dr Jackson without question and actively requested extra takeaway doses and repeat prescriptions on behalf of patients, knowing that their stability had not been assessed and knowing, based on experience with Dr Jackson that it was unlikely Dr Jackson would take any further steps to ascertain the level of stability himself."<sup>238</sup>*

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238 Paragraph 37.

214. I respectfully agree with this analysis. Mr Jacometti's evidence was most unsatisfactory, in my view. It was very difficult to understand his responses to many questions. He simply failed to give coherent, consistent or satisfactory answers, despite being given every opportunity to do so. He vacillated in answers on numerous matters, seemingly to avoid blame or criticism. He did not appear reflective about aspects of his work with Dr Jackson, except the poor standard of his notetaking.
215. He was particularly evasive and contradictory in discussing his actions of facilitating prescribing, even new medications, without appointments. He was not forthcoming with the significant extent of the prescribing over the phone or via electronic means without any patient assessment to ensure stability.
216. His reluctance to answer honestly questions about prescribing a benzodiazepine to Mr Brown as a new client was characteristic of his reluctance to be frank on matters involving obviously unsafe or inappropriate practice.
217. It is neither an overstatement nor unfair to say that Mr Jacometti was an acolyte of Dr Jackson. He deferred to his authority, carried out his instructions without question and enabled his decisions.
218. It was plain from Mr Jacometti's police interviews and court evidence that he largely adopted Dr Jackson's approach to facilitating supply to patients with substances they requested, without reference to the TOPP guidelines. His intentions were not malicious. Like Dr Jackson, he held the overriding belief that drug dependent patients could be "saved" by their services in light of the lack of spots on other programs and lack of other options. Their views appeared to be premised upon the simple fact that prescribing opioid replacement substances (and other substances, such as benzodiazepines) even without usual checks and balances, saves lives by preventing patients sourcing drugs illicitly and succumbing to accidental overdose.
219. A paramount consideration for Mr Jacometti and Dr Jackson, in delivering pharmacotherapy, was that patients must be trusted and respected, and not questioned or labelled as "*liars*".
220. However, it is clear from the expert and other evidence, that both were misguided in terms of balancing the needs or wants of the patients with safety considerations and the risks inherent in opioid pharmacotherapy.

### Mr Jacometti's points of contention

221. As should be clear from the preceding analysis of Mr Jacometti's evidence, he submitted that:

- He was subordinate in his professional relationship with Dr Jackson by virtue of his role and his qualifications;
- Dr Jackson, as the specialist medical practitioner, was responsible for the treatment of, and decisions made in respect of, the pharmacotherapy patients; and
- He relied upon Dr Jackson to treat the patients in accordance with appropriate standards.

### *The pharmacists*

222. Five pharmacists were represented by the same counsel, Ms Walsh, at inquest. Each pharmacist dispensed takeaway methadone, according to Dr Jackson's prescription, to one of the deceased. The issue to be examined in relation to the pharmacists and their prescribing was whether there was a role played by the pharmacist in the circumstances of the death of each deceased.

223. The pharmacists and their respective dispensing events/involvement were as follows:

- Michael Nash, employee of Jerry Hampton, dispensed methadone, including takeaway doses, to Mr Brown four days before his death.
- Mary (Marjorie) Cook, employee of Jerry Hampton, dispensed takeaway methadone, including takeaway doses, to Mr Brown the day before his death.
- Wendy Steinberg dispensed methadone, mirtazapine, a benzodiazepine and pregabalin to Ms Kemp two days before her death over the two days before her death.
- Stephen Ives dispensed methadone takeaway doses to Mr Winwood three days before his death.
- Jerry Hampton gave evidence as pharmacy owner and very experienced ORT pharmacist. Further, Ms Wiki was dispensed methadone (including a takeaway dose) the day before her death at his pharmacy.

224. I will deal in more detail with the pharmacists' relevant involvement with each of the deceased in the time close to their deaths.

### Pharmacists' points of contention

225. Counsel for the pharmacists, Ms Walsh, raised the following issues in submitting that no adverse comment regarding actions or decisions by the pharmacists should be made in this inquest.<sup>239</sup>
- (a) That methadone toxicity was not the cause of any of the four deaths, except that of Mr Brown.
  - (b) That Ms Kemp did not die as a result of methadone toxicity, but as a result of natural causes, being pneumonia and possible arrhythmogenic cardiomyopathy.
  - (c) Ms Wiki did not die as a result of methadone toxicity but as a result of acute cardiovascular collapse due to intravenous injection of insoluble tablet excipients in the setting of pre-existing extensive pulmonary intravascular foreign body granulomas.
  - (d) That Mr Winwood did not die as a result of methadone toxicity but of positional asphyxia by being wedged in the footwell of the caravan in the setting of possible alcohol withdrawal, foot injury with associated likely hypovolaemic shock, long-standing lower limb weakness, heart and lung disease, and possible effects of medications.
  - (e) It cannot be determined upon the evidence that methadone detected in Mr Brown's postmortem blood sample derived from his personal prescriptions from Dr Jackson and dispensed by Mr Nash, and more relevantly, Ms Cook. This is because Mr Brown's house contained evidence and paraphernalia of other methadone takeaway doses dispensed to his partner, his aunt or another third party, presumably diverted. It was also submitted that, apart from the police officers finding drugs at the scene of death apparently from other sources, there was a reasonable chance that Ms McCoy, his partner, had concealed illicitly sourced drugs from the attending officers.<sup>240</sup>
  - (f) All pharmacists adopted proper and reasonable professional practice in dispensing to the deceased.
  - (g) The submission by counsel assisting that Ms Steinberg should not have dispensed methadone to Ms Kemp, who was ill, was unwarranted. Ms

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<sup>239</sup> Submissions on behalf of the pharmacists dated 28 March 2025, and 28 April 2025.  
<sup>240</sup> Submissions on behalf of the pharmacists dated 28 March 2025, page 4-7.

Walsh submitted that Ms Steinberg acquitted her professional duty and exercised proper professional judgement in dispensing to Ms Kemp. Further, any critical comments regarding her actions, assuming it is in within scope to make them, would necessarily be affected by hindsight bias. This is because Ms Steinberg could not have known at the time of the dispensing that her generalised symptoms of cough, shortness of breath, paleness, tiredness and being unwell would lead to her ultimate death from pneumonia.<sup>241</sup>

226. Counsel assisting did not, in their closing submissions, suggest that I make adverse comment against any of the pharmacists, except Ms Steinberg.
227. It is appropriate to comment at this point that, after hearing all of the evidence at inquest, I have formed the view that none of the five pharmacists should be criticised for dispensing Dr Jackson's prescribed methadone to any of the deceased. The reasons for this conclusion will be set out further in this finding.
228. Essentially, it was plain from the large body of evidence in the investigation and at inquest relating to the duties and role of pharmacists, that individual dispensing events were undertaken completely in reliance upon the skill, judgement and instructions of the prescribing doctor- in this case, Dr Jackson.

## **Nicholas Shane Brown**

### *Background*

229. Nicholas Shane Brown was born on 29 July 1981, in Hobart to William Shane Brown and Karen Jane Ware (now deceased). He was the oldest of six children and identified as Aboriginal. His parents never married, and they separated during his early childhood. Following his parents' separation, Mr Brown lived with his mother and continued to see his father.
230. The following account of Mr Brown's life, relationships and struggles comes principally from his father, William Brown<sup>242</sup> who swore one affidavit and one statutory declaration for the inquest. He gave candid and heartfelt unchallenged oral evidence.<sup>243</sup>
231. When Mr Brown was about 8-10 years of age, he moved to South Australia

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241 Submissions on behalf of the pharmacists dated 28 April 2025, page 7-9.

242 Known by the Christian name of "Ricky".

243 NB6 and NB7; T213-232.

with his mother. Whilst living there, Mr Brown rarely went to school and this rendered him effectively illiterate.

232. Mr Brown's earliest involvement with Tasmania Police was in 1995 as a 13-year-old. By the time of his death, he had a record of offending in Tasmania, New South Wales and Queensland.<sup>244</sup>
233. At the age of 15 years, he found himself living on the streets in Sydney. He contacted his father who arranged for him to fly to Tasmania. He stayed with his father for three or four months before moving to Queensland to again live with Ms Ware.
234. Whilst living in Queensland, his mother was in a volatile relationship. Mr Brown would often defend her and find himself in a physical altercation with her partner. Mr Brown was subsequently forced to leave again but remained close to his mother.
235. It was around this time that Mr Brown began using heavier drugs, stealing cars and breaking into houses. He told family members that the constant exposure to his mother suffering domestic violence had affected him throughout his life. His father said that he also became a heavy cannabis user.
236. Mr Brown moved to Southport on the Gold Coast where he lived for several years. During this time, he was able to secure some labouring work.
237. While on the Gold Coast, at the age of 18 years, he met Theresa Hensby<sup>245</sup> and within weeks she was pregnant. In 1998, their daughter, Candice Theresa Hensby, was born. Mr Brown's relationship with Ms Hensby was short lived, with both likely using heavy drugs at that time. Ms Hensby died in 2014.
238. In his early twenties, Mr Brown moved to Kempsey, New South Wales. Here he met Belinda Hemmy, and they had a son, Marshall Michael Hemmy, who was born in 2004. Ms Hemmy was also a heavy drug user and their relationship was violent.
239. At the age of 24 years, Mr Brown formed a relationship with Gemma Hay, who he had known from his childhood in South Australia. They lived together for

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244 NB 67 Tasmanian criminal record.

245 In his affidavits and oral evidence, William Brown referred to Candice's mother as "Kathleen". This may have been the name used by Theresa Gaye Hensby (date of birth 18 May 1981).

about 12 months, but during this time Mr Brown became violent. He was ultimately arrested on outstanding warrants from when he was a youth and subsequently spent time in prison.

240. Following his release from prison, Mr Brown and Ms Hay had a son, Tyrece Paul Brown, born in 2007. The relationship between Mr Brown and Ms Hay was good for a period and Mr Brown's drug use decreased. However, that situation did not last and their relationship broke down.
241. At about the age of 27 years, Mr Brown met Cindy Baker and they had two children together: Harmony Baker-Brown born in 2009 and Phoenix Baker-Brown, born in 2014. Between the birth of his two children, Mr Brown was incarcerated for about four years in prison in Queensland for an armed robbery committed in 2009.
242. Ms Baker was not a drug user but Mr Brown's drug use continued throughout their relationship which lasted five years. They separated in 2014 when Mr Brown moved to Tasmania to receive help for his drug addiction. It appears that he was also struggling with his mother's death in 2010.
243. In July 2014, Mr Brown moved in with his father and his step-mother, Emilee Brown, in Herdsmans Cove. He told his father he had been abducted over a drug debt and assaulted. His father observed bruises upon him consistent with this account.
244. In August 2014, he commenced the Salvation Army Bridge Program. Whilst participating in the program Mr Brown met Melissa Jane McCoy.<sup>246</sup> They maintained a relationship up until his death and were engaged. During this time Ms McCoy moved into Mr Brown's unit in New Town.
245. In his evidence in court, William Brown described his son as a happy young man in his early years. He loved his sport, especially football, and was a bit of a joker. He said that his son loved his five children and always made time to contact them and spend time with them. He described Mr Brown's children as being devastated as they are coming to realise that they will not be able to talk to him or see him or share important events with him again.
246. William Brown said that his son always took pride in himself and how he looked. In evidence, William Brown spoke of his son's desire to stop using

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246 Date of birth 1 June 1981 (aka BANNISTER).

drugs, by moving back to Tasmania to live with his him and stepmother, where they helped him to enter rehabilitation. William Brown described Mr Brown's happiness at being accepted into the Salvation Army facility where he hoped he could overcome his addiction. William Brown said that Mr Brown was prepared to go through "*all of the long haul.*"<sup>247</sup>

### *History of drug use*

247. Mr Brown had been a drug user for most of his life and almost all his significant relationships were marred by drug use. Documents from Mr Brown's time in prison in Queensland between 2009 and 2013 identified that Mr Brown had, throughout his life, abused alcohol, amphetamines, heroin, morphine, methamphetamine ("*ice*") and cannabis.
248. Mr Brown was first registered on the NSW Opioid Treatment Program in June 2002 and was being cared for by Dr Fares Samara. He was prescribed buprenorphine initially but was transitioned to methadone. He remained on the program until May 2005.
249. In June 2005, while in Tasmania, Mr Brown was briefly prescribed methadone by Dr Shaunagh Jones, but this stopped in September 2005 when Mr Brown returned to New South Wales. He continued to be cared for by Dr Samara until January 2006.
250. From November 2011 to January 2012, Mr Brown was being treated by the Logan Alcohol and Drugs Service in Queensland, where he was prescribed buprenorphine (Suboxone). He left the program for a period of time before returning in March 2014 and was again prescribed Suboxone. In July 2014, Mr Brown left the program without notice.
251. In July 2014, Mr Brown returned to Tasmania and shortly after commenced drug addiction rehabilitation with the Salvation Army Bridge Program. It was here that he met Mr Jacometti who, in turn, introduced him to Dr Jackson, who subsequently took over his treatment until his death.
252. On 1 August 2014, Mr Brown attended the Tasmanian Aboriginal Health Service and was seen by Dr Dianne Hopper. He informed Dr Hopper that he was an intravenous drug user and had recently arrived from Queensland where he had been on Suboxone. At this time, he was prescribed pregabalin.

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247 T215.

253. On 22 September 2014, Mr Brown commenced the day program of the Salvation Army Bridge Program.
254. Dr Jackson first saw Mr Brown on 24 September 2014. He was prescribed 50 x 5mg diazepam tablets to take two tablets three times a day (30mg total per day). He was also prescribed 8mg Subutex and was permitted one takeaway dose per week. Mr Brown's first day of dosage was on 30 September 2014.
255. On 7 October 2014, Mr Brown's dosage was increased to 10mg Subutex and he continued to be permitted one takeaway dose per week. There is no Medicare record of Dr Jackson seeing Mr Brown on this date.
256. Dr Jackson did not have authority to prescribe Subutex on 29 September 2014 or 7 October 2014. It was not until 8 October 2014 Dr Jackson submitted a Section 59E application to PSB. The authority was granted on 9 October 2014.
257. On 8 October 2014, Mr Brown commenced the residential program of the Bridge Program. He progressed well on the program and was engaging with services. During this time, he was referred to a psychologist, Dr Maddi Derrick, but enquiries by investigating officers reveal that he never attended consultations with her.
258. On 28 October 2014, Mr Brown was prescribed Subutex 16mg daily and three takeaway doses per week.<sup>248</sup>
259. On 3 November 2014, Bridge Program staff spoke to Dr Jackson about the mix of Mr Brown's Subutex dose and diazepam because he appeared affected by the combination. Staff recorded following that discussion that Dr Jackson agreed that Mr Brown should not return to taking diazepam. Dr Jackson's notes correspondingly indicated that he stopped Mr Brown's benzodiazepine prescription.<sup>249</sup>
260. Mr Brown continued on the Bridge Program until 19 November 2014, when he returned a positive urine test for benzodiazepines, despite his prescription for diazepam being stopped earlier in the month. He was subsequently asked to leave but continued to be cared for by Dr Jackson.
261. On 21 November 2014, Mr Brown was prescribed Subutex 20mg daily with three takeaway doses per week. There is no Medicare record of Dr Jackson

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248 CNB10L page 84.

249 NB 10e page 33.

- seeing Mr Brown on this date.
262. On 8 December 2014, Mr Brown secured a unit in Bedford Street, New Town. The unit was 800 metres from the Lenah Valley Amcal Pharmacy (LVAP') where Mr Brown was receiving his medication.
263. The dosing records for LVAP for December 2014 record that Mr Brown received 14 takeaway doses of Subutex during that month.<sup>250</sup>
264. On 19 January 2015, Mr Brown's Subutex was increased to 24mg per day with three takeaway doses per week. There is no Medicare record of Dr Jackson seeing Mr Brown on this date.
265. On 31 March 2015, Dr Jackson reduced Mr Brown's Subutex to 14mg daily with three takeaway doses per week. There is no Medicare record of Dr Jackson seeing Mr Brown on this date.
266. On 22 May 2015, Dr Jackson wrote a further prescription for Subutex 18mg per day with three takeaway doses and a prescription for diazepam 50 x 5mg tablet, taken as one tablet three times day. The next day at 2.15am Mr Brown contacted Ambulance Tasmania and was taken to the RHH. At the time, he told paramedics he had overdosed on diazepam, consumed wine and caused self-inflicted superficial lacerations to himself. RHH records indicate he had taken 65 x 5mg tablets in the previous 12-24 hours. Despite Mr Brown's overdose, three days later Dr Jackson issued a 'replacement script' for 18mg Subutex with three takeaway doses per week. A lack of note taking makes it difficult to say whether Dr Jackson was aware of Mr Brown's overdose. RHH records do not indicate they forwarded this information to Dr Jackson.
267. On 29 May 2015, seven days after Mr Brown's overdose, Dr Jackson issued a further replacement prescription for 50 x 5mg diazepam tablets to be taken as one tablet three times a day. The only explanation in Dr Jackson's medical notes was "*lost previous script in Melbourne*".<sup>251</sup>
268. On 8 June 2015 and 17 July 2015, Dr Jackson issued two further replacement prescriptions for 50 x 5mg diazepam. On the first occasion, Mr Brown claimed to have misplaced his prescription and on the second occasion, that it had been taken by police. Medical records from Dr Jackson identify that, in both

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250C NB11.

251 CNB10L p.73.

instances, the only evidence given to support these claims was from Mr Brown or Ms McCoy. Tasmania Police records show that Mr Brown was arrested on 17 July 2015 but his prisoner property record only identified an *'empty pill bottle and packet'*.

269. On 27 July 2015, Mr Brown again claimed his prescription had been taken by friends when he fell asleep. Dr Jackson issued a replacement but changed his future diazepam dispensing regime to be dispensed with his Subutex.
270. On 10 August 2015, Dr Jackson issued a prescription for 50 x 5mg diazepam and this was dispensed with Mr Brown's Subutex. On 21 August 2015, Dr Jackson again issued a prescription for 50 x 5mg diazepam but there was no notation requiring it to be dispensed with his Subutex and LVAP records indicate the prescription was dispensed in full. Mr Brown continued to be permitted to be dispensed his diazepam in full until his death.
271. In December 2015, Dr Jackson moved Mr Brown's dispensing to the Guardian Elizabeth Street Pharmacy ("GESP").
272. On 1 February 2016, the owner of GESP, pharmacist Olivia Gillie, contacted PSB concerned about the number of takeaway doses Mr Brown was receiving. Ms Gillie's concern was based on Mr Brown not only receiving more takeaway doses per month than permitted by the Tasmania Opioid Pharmacotherapy Program (TOPP), but also more than Dr Jackson was prescribing. In the month of January 2016, Mr Brown received 20 takeaway doses, despite only being prescribed three per week or 12 takeaway doses in a 28-day period.<sup>252</sup>
273. Ms Gillie was right to be very concerned and right to make contact with PSB. PSB recorded her concern and simply advised her to make contact with Dr Jackson regarding the matter.
274. Ms Gillie's notification to PSB occurred nearly 8 months before Mr Brown died. PSB should have done more on this occasion than placing the onus back onto Ms Gillie to take up the matter with Dr Jackson. After hearing the evidence at inquest from numerous diligent pharmacists, it is clear that they are trained to recognise risks and safety issues in ORT but are understandably reluctant to challenge the prescriber to any significant degree. PSB missed a critical opportunity to further investigate and take steps to curb Dr Jackson's prescribing. If necessary, AHPRA could have been notified.

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252 NB21 Affidavit Olivia Gillie.

275. On 28 June 2016, three months before his death, Mr Brown presented to Dr Anna McKinlay at the Tasmanian Aboriginal Health Service with a rash on his left wrist.<sup>253</sup> He advised me that he had been injecting his take home methadone. She could not recall whether Mr Brown advised her or whether she made the assumption that it was methadone rather than buprenorphine.<sup>254</sup>

276. In her statutory declaration, Dr McKinlay referred to the consultation:

*“We discussed the need for him to discuss this with Dr Jackson whom I knew was prescribing Nick with pharmacotherapy medication. Nick rang him during the consultation. I recall the conversation with Dr Jackson was very brief. We introduced each other so we knew who each other was. I explained the situation as I was concerned that Nick was injecting his regular medications.”<sup>255</sup>*

277. Dr McKinlay gave helpful and credible evidence at inquest. Despite challenge from counsel for Dr Jackson, she was firm that she did speak directly to Dr Jackson to advise him that Mr Brown was injecting his takeaway doses. I find that the conversation occurred. It demanded immediate cessation by Dr Jackson of takeaway doses, but this did not occur.

278. On 19 August 2016, Mr Brown was remanded in custody on low value stealing charges. He was sentenced in the Hobart Court of Petty Sessions to a total of 35 days imprisonment.<sup>256</sup> Whilst incarcerated, Mr Brown authorised the exchanges of his medical information between the prison and Dr Jackson. Dr Jackson faxed a copy of Mr Brown’s current prescriptions which included Subutex 26mg daily, Lyrica 300mg twice daily, Nexium 40mg daily and diazepam 10mg three times daily. Mr Brown’s medication was reviewed by Dr Christopher Wake, senior specialist medical practitioner and head of the Department of Correctional Primary Health Services. He made the decision to swap Mr Brown onto 26mg Suboxone because the prison does not carry Subutex and reduce diazepam from 5mg twice daily to 5mg once a day after seven days and then ceasing three days later with the last dose being the 28 August 2016.

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253 Mr Brown attended this practice for non-ORT medical issues. Dr McKinlay gave evidence that it was not unusual for an ORT patient to see two doctors, one of who administered the ORT.

254 NB18 Statutory declaration Anna McKinlay, page 2.

255 Ibid.

256 NB67 Complaint numbers 6260/15 and 1730/2016.

*Circumstances surrounding the death of Mr Brown*

Release from Prison 22 September 2016

279. At 9.31am on 22 September 2016, Mr Brown was released from Risdon Prison and was collected by Ms McCoy. Mr Brown immediately attempted to contact Dr Jackson by phone but was not able to reach him until 2.45pm. Ms McCoy stated in her affidavit that Mr Brown told Dr Jackson on the phone that whilst in prison he was on 60mg methadone per day. She said that Dr Jackson accepted Mr Brown's word for this. In her statutory declaration of 23 June 2019, she said:

*"So the day Nick was released I went over and collected him in my car. We went back to his unit in Bedford Street. Nick called Dr Jackson on the phone, which I couldn't make sense of, as you'd think he'd want to see him if he just got out of jail. Nick lied to him and said that while he was in jail, they swapped him onto the methadone. I don't know why he just didn't ask him, as I know he wanted to be on the methadone. I could hear the conversation on Nicks phone, it wasn't on speaker but was really loud, Dr Jackson said "ohh what milligrams are you on", Nick turned round and said "60" and even I thought "Fuck", because when you first start on it, I know they only put you on 20 or 30 milligrams of it. Dr Jackson said, "are you sure", and Nick said "yeah..., is it alright if I go up the chemist and get my medication and some takeaways". He [Jackson] authorised it and didn't even see him."<sup>257</sup>*

280. Although Ms McCoy's evidence requires scrutiny before being accepted, I fully accept the frank account she provided of Mr Brown's telephone call to Dr Jackson made in her statutory declaration, as well as in her interview and court evidence.<sup>258</sup>

281. Moreover, Dr Jackson himself, in his affidavit of 17 February 2017 gave the following account:

*"In mid-August 2016, I received a request from the Hobart Remand Centre to provide a list of medications being prescribed to Mr Brown. I duly faxed the list to the Remand Centre on 19 August 2016. The list was*

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257 NB5.

258 NB3 page 2; T70-71.

*of Subutex Sublingual tablets at the dose of 26mg daily; Lyrica 300mg twice daily; Nexium 40mg daily; and diazepam 10mg three times daily.*

*I then heard nothing of Mr Brown until late on 22 September 2016 when I spoke to him and his partner on the telephone. Mr Brown explained that he had been released from Risdon Prison earlier that day. He said that while an inmate, his medication had been changed from 26mg of buprenorphine to 60mg daily of methadone (an alternative medication for opioid pharmacotherapy) and that his last dose in prison had been given on that day, the 22nd of September.*

*Mr Brown and his partner also said that she had arranged a long weekend at Cradle Mountain, starting the next day, as sort of a celebration at being released from prison. He requested take away doses for the three days.*

*By this time, it was late on the Thursday and I was unable to fit in a face-to-face appointment. However, my judgement, based on my treatment of Mr Brown over a two year period and his presentation on the telephone, was that I would not prevent his booked holiday. Consequently, I arranged with his dispensing pharmacy (North Hobart Amcal Pharmacy) to provide a three day supply of methadone 60mg daily and diazepam 20mg daily, but no other medications. I also arranged that he would see me on the following Monday, 26 September 2016.”<sup>259</sup>*

282. This was, in fact, a lie for the purpose of securing a supply of methadone. Neither Mr Brown nor Ms McCoy were travelling to Cradle Mountain or anywhere at all. It was also of course a deliberate lie by Mr Brown to Dr Jackson to secure methadone for the purpose of its abuse or misuse. Even Ms McCoy, drug dependent herself, expressed concern with Mr Brown commencing suddenly on a significant dose of methadone.
283. Accordingly, at 2.59pm Dr Jackson sent a fax to WHAP requesting that they dispense Mr Brown three takeaway doses of methadone 60mg for Friday 23, Saturday 24 and Sunday 25 September 2016. Dr Jackson authorised the takeaway doses and issued an ongoing prescription to Mr Brown for 60mg methadone per day plus three takeaway doses per week.<sup>260</sup>

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259 NB 13.  
260 CNB21g.

284. At 3.30pm Mr Brown collected his three takeaway doses of methadone and diazepam for the alleged trip to Cradle Mountain. Interestingly, Dr Jackson's fax to the WHAP was overly reassuring when the facts did not justify such:

*"Dear Pharmacist Nicholas has been released from prison today, where he was changed onto methadone, last dose 60 mg today. He has arranged a trip to Cradle Mountain, heading up today, so could he start back on with 3 (three) TAD, Fri-Sun Regards".* <sup>261</sup>

285. It appears from Dr Jackson's affidavit of 17 February 2027 that Mr Brown actually told him that he was leaving for Cradle Mountain not the day of his release but the following day.<sup>262</sup> If it was in fact the following day, then there would be no impediment to Mr Brown attending the pharmacy for in-person dosing. Further, Dr Jackson at this time issued an ongoing prescription to Mr Brown for a two-month supply of methadone, despite Mr Brown not having previously been prescribed methadone in Tasmania; and, despite asserting that he would see Mr Brown in person in four days' time, being Monday 26 September 2016.
286. It is obvious that an in-person consultation with a recently released prisoner on a different form of opioid replacement therapy would be required so that careful assessment may be conducted by the practitioner.
287. Further, there is no independent evidence to support Dr Jackson having ever made enquiries with the prison about what Mr Brown was prescribed whilst incarcerated. I will deal with this aspect later in the finding.
288. Nevertheless, the pharmacist Michael Nash, cannot be criticised for dispensing the methadone takeaway doses. He had received a completed prescription and an explanatory note, coherent on its face, from a medical practitioner, he was comfortable with the contents of Dr Jackson's fax, especially knowing that Dr Jackson was his regular treating doctor and there were reasons for the request.<sup>263</sup>
289. Mr Nash also gave evidence that the DORA real time prescription monitoring system available to pharmacists at the time did not give information about the type of opioid replacement last prescribed or dispensed to the patient - only the fact that opioid pharmacotherapy had been dispensed and where it had

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261 CNB 21 L.

262 NB13 page 3.

263 T305 and T308.

been dispensed<sup>264</sup> I accept his evidence on this point.

290. Mr Nash also made the point that the experienced doctors did not necessarily reduce their patients' takeaway doses to conform with the introduction of the stricter guidelines in the TOPP. He gave evidence that those doctors were able to adequately manage the safety and stability of their patients.<sup>265</sup>
291. I do not consider that there was anything more that Mr Nash should have done before dispensing to Mr Brown in accordance with Dr Jackson's instructions.
292. I note that at 9.55am the following day, 23 September 2016, Ms McCoy actually attended WHAP and received her 85mg methadone dose, plus three takeaway doses for 24, 25 and 26 September 2016.

The day prior to death, Monday 26 September 2016

293. At 7.58am on Monday 26 September 2016, Mr Brown called Dr Jackson, who was at the Hobart Clinic.
294. Mr Brown's phone records show that between 9.35am and 9.41am a series of text messages were sent between Mr Brown and Ms McCoy. At the time, Mr Brown was waiting at the WHAP to be dosed. In the texts, they discussed how Mr Brown could try and obtain extra takeaway doses of methadone.<sup>266</sup>
295. At 9.40am Mr Brown was dosed at the pharmacy and given his four diazepam tablets for the day to take away. At 9.44am Mr Brown attempted unsuccessfully to call Mr Jacometti. He tried again at 9.46am. At 9.53am Mr Jacometti returned Mr Brown's call.<sup>267</sup>
296. At 10.00am Mr Jacometti sent a fax to WHAP, "*Dear Marg please could Nicholas Brown have x2 extra takeaway doses (methadone 60mg) brought forward with pick up today. Due to interstate travel. Thankyou.*"<sup>268</sup>
297. Despite the fact that a medical practitioner must prescribe takeaway doses, Mr Jacometti sent this fax without having discussed this at all with Dr Jackson. In evidence, Mr Jacometti was unable to explain why he sent this and

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264 T340.

265 T332-3.

266 NB 60a and NB 61b.

267 NB 61a.

268 CNB21k and NB62.

acknowledged that the pharmacist could not dispense on his authority.<sup>269</sup>

298. The pharmacist, Marjorie Cook,<sup>270</sup> who had been involved with the pharmacotherapy program since about 1997, was the pharmacist at WHAP attending to Mr Brown that day. She recalled Mr Brown coming into the pharmacy for his dose and in the expectation that takeaway doses would be authorised by Dr Jackson. She said that when Mr Jacometti's fax arrived she was unable to accept this as authority as it was not signed by Dr Jackson. She said that she then made attempts to contact Mr Jacometti to tell him that this was not acceptable.
299. Between 10.10am and 10.48am a series of calls are made between Dr Jackson and Mr Jacometti, Mr Brown and Mr Jacometti and Ms McCoy and Mr Brown. Ms Cook then obtained verbal authorisation from Dr Jackson, recalling information about the takeaway doses being required due to a relative being involved in an accident in Queensland.
300. Finally, at 10.50am, Mr Brown received two takeaway doses of 60mg methadone and 8x 5mg diazepam tablets. The pharmacy dosing chart states, 'early as per Dr Jackson phone'.<sup>271</sup> Ms Cook also made a note on the fax from Mr Jacometti "authorised by Dr Jackson".<sup>272</sup> I accept the evidence of Ms Cook that Mr Brown did not present as intoxicated or under the influence at any stage during this day such that Ms Cook might have concerns about dosing him or providing takeaway doses.
301. Between 3.15pm and 4.46pm a further series of phone calls were made by Mr Brown to Dr Jackson, culminating in Dr Jackson sending a further fax at 4.53pm to WHAP stating:

*"Dear Pharmacist, could Nicholas please pick up two extra takeaway doses – so 4 altogether today – to take to Queensland as he will be there for a few days – daughter not expected to survive. Many thanks."*<sup>273</sup>

I agree with counsel assisting that it does not appear upon the evidence, including phone records that Mr Jacometti was involved or made any calls to Dr Jackson, WHAP or Mr Brown in respect of the second authorisation of

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269 NB16a at page 34-5.

270 Christian name "Mary" but uses the name "Marjorie".

271 CNB21e.

272 NB 25 Affidavit Mary Cook.

273 CNB21j.

takeaway doses of methadone and diazepam to Mr Brown.

302. There had been false information provided by Mr Brown that his daughter had been involved in a vehicle accident and subsequently, that her injuries were so severe she might not survive. This information was provided by Mr Brown over the course of the day in order to manipulate Dr Jackson and Mr Jacometti into providing him with more takeaway methadone and diazepam.
303. In his affidavit of 27 March 2017, Mr Jacometti said as follows about the situation:

*“...I remember speaking with Nicholas Brown on 26 September 2016. Nicholas had my mobile number. Nicholas rang me and was really upset and stated he needed to get up to Queensland as his daughter had been seriously hurt and he needed to go urgently. Nicholas rang me so I could get in touch with Dr Jackson, at this time I would have been at work.*

*During this phone call I was aware that Nicholas was not in prison and was on methadone 60mg as per my notes and was allowed three takeaway dosages. I’m not sure what date this started. I phoned Dr Jackson straight after I spoke with Nicholas and told him about the phone call and said we needed to organise some extra take aways for Nick to get to Queensland. The takeaway dosages are left up to Dr Jackson to determine.*

*Dr Jackson would have then written a script out and sent off to the Pharmacy.”<sup>274</sup>*

304. At 5.10pm Mr Brown picked up the additional methadone and diazepam doses from WHAP.
305. Therefore, on 26 September 2016, Mr Brown received a total of five 60mg doses of methadone and 20 x 5mg diazepam tablets from the WHAP.
306. In evidence and in her affidavit, Ms Cook said that she would always dose a patient as prescribed by the doctor unless they were intoxicated or presenting with behaviour issues. She said that it is up to the doctor to be satisfied as to the reasons for the patient requiring takeaway doses. She was not aware of the fact Mr Brown had been previously prescribed buprenorphine and changed

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274 NB 15.

to methadone and said that she was just following the prescription and dosing charts.

307. It can always be said that, in hindsight, it should have been apparent that the quantity of takeaway doses prescribed to Mr Brown was highly unusual at the time. Ms Cook said in evidence at inquest that she noted that Mr Brown had received three takeaway doses dispensed by Mr Nash the day after he was released from prison, being three days before Ms Cook's dispensing to Mr Brown. When questioned, she said that she had no concern about this despite being asked to dispense takeaway doses again three days later.<sup>275</sup>
308. Ms Cook, retired at the time of giving evidence, was a very experienced pharmacist and trained specifically in ORT. Her evidence was considered and reasonable. She acted prudently in not accepting the faxed request from Mr Jacometti. She said that it was not unusual to receive additional instructions from doctors, particularly Dr Jackson, regarding dispensing additional takeaway doses. She said that she had no reason not to accept the reason given for prescribing further takeaway doses of methadone and diazepam. She recalled that Mr Brown himself told her about his daughter's accident and the fact that he was at the pharmacy with a female also was consistent with the situation.<sup>276</sup>
309. Ms Cook said firmly that if Mr Brown had been intoxicated or had been behaving unacceptably, she would not have dispensed the takeaway doses. I accept her evidence. She said that she had previous cause to query the number of takeaway doses prescribed to other patients,<sup>277</sup> and was aware of the TOPP guideline that, in general, only two takeaway doses per week should be prescribed.
310. As the police investigation proceeded, in April 2017 an affidavit was obtained from the mother of Mr Brown's daughter, Cindy Baker, who said that daughter had not been involved in a motor vehicle accident or anything similar.<sup>278</sup>
311. Ms McCoy provided evidence that on 27 September 2016, Mr Brown went into the bathroom at their New Town unit to inject his takeaway methadone. She believed that he also took his diazepam tablets at that time. She described him

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275 T730-734.

276 T707 and following.

277 T736-8 regarding three takeaway doses every four days prescribed to Mr Winwood by Dr Jackson.

278 NB9.

as “pretty groggy” throughout the day.<sup>279</sup>

312. At inquest, Ms McCoy maintained the basic account she had given in her previous evidence regarding the day of Mr Brown’s death. She was not an impressive or necessarily reliable witness in giving oral evidence in any matters. She appeared as if she may have been affected by substances in the witness box.
313. She maintained that she did not give her prescribed methadone to Mr Brown ever, even though she swapped other prescription drugs with him. She was also vague about the methadone bottle in the name of Wayne Leary and whether it was her or Mr Brown who consumed it.
314. Ms McCoy agreed that Carol Brown, Mr Brown’s aunt, did not supply her or Mr Brown methadone after his release from prison; this is consistent with Ms Brown’s frankly given evidence and I find it as a fact.
315. I doubt that it is correct that Ms McCoy never gave Mr Brown methadone. If she received two takeaway doses on 27 September 2016, it might be possible that she gave one to Mr Brown. I fully accept the evidence of the ambulance officer that Ms McCoy removed drug paraphernalia, including plastic bottles (which resembled methadone bottles) and “*baggies*” from the scene.<sup>280</sup> I find that she gave false evidence that she only removed a phone and a handbag from around Mr Brown’s deceased body.<sup>281</sup> I do not accept her constant denials in this regard.
316. It is clear from her evidence that Ms McCoy was very concerned about the use of methadone by Mr Brown in light of his likely intolerance after not having used it in prison.
317. Although she said in evidence at the inquest that she did not recall seeing him injecting methadone, in her statement of 27 September 2016 she positively stated she saw him injecting methadone into his thumb.<sup>282</sup> She may well have injected methadone with him that day. There were plenty of opportunities. She was noted by the first police officer on the scene, an experienced officer, to be under the influence. Knowledge that Mr Brown had injected would explain the

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279 CNB5 page 2.

280 A “baggy” is a colloquial term for a small plastic bag used for holding small quantities of drugs.

281 T140.

282 NB1-Brown – Stat dec Melissa McCoy.

reason for her concern, her call to the ambulance and her return home.

318. At around lunch time, Mr Brown and Ms McCoy were picked up by Ms McCoy's father's partner, Michelle Gordon. Ms Gordon drove them into town to purchase a wedding dress for Ms McCoy as she and Mr Brown were to be married the following Friday. Ms Gordon recalled that Mr Brown appeared at times to be nodding off and his words were often slurred. She says she knew that Mr Brown was under the influence of drugs.
319. Ms Gordon is a non-drug user. She gave clear responsive and credible answers from a video link interstate in accordance with her affidavit.<sup>283</sup> She was aware of drug use of Mr Brown and Ms McCoy but did not become involved or ever enquire of them about this issue.
320. She said that she had seen Ms McCoy in a drowsy state previously and assumed that it was due to drug use. On 27 September 2016, she spent much time in their company helping with their wedding tasks. She said that she had seen Mr Brown likely under the influence previously with drooping eyes but on this particular day it was worse. Quite understandably, she did not raise the issue with him and thought that such a state was not likely to be concerning. She explained that she simply did not know about the effects of any drugs and what she should be concerned about. She was not with them the whole day, they both went home before meeting her at Glenorchy in the afternoon and after that they both went home together. There was clearly opportunity for them both to consume drugs without Ms Gordon knowing.
321. Later that afternoon Ms Gordon dropped Mr Brown and Ms McCoy home before meeting them a short while later, at the Northgate shopping centre to drop Ms McCoy's dress off to be altered. Ms Gordon says that while they were at the alterations shop, she noticed Mr Brown must have fallen asleep because he was sitting upright, before falling forward and then jolting awake. After they finished at the alterations shop, Ms Gordon left Mr Brown and Ms McCoy and went home.<sup>284</sup>
322. At 4.40pm, Ms McCoy received her 85mg methadone dose at WHAP. She went to work at the Goulburn Street Massage Parlour. She said that she left for work between 5.00pm or 5.30pm. She was unsure in evidence how she

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<sup>283</sup> T160-169.

<sup>284</sup> Ms McCoy's statutory declaration at NB1 states they returned home about 5pm but it is likely to be earlier in the afternoon.

travelled to work but her statutory declaration refers to driving back to the unit after work.<sup>285</sup>

323. At 4.46pm, closed circuit television footage from the Augusta Road Hill Street Grocer shows Mr Brown walking through the car park alone. At 4.48pm, Mr Brown is seen entering the store and then paying for some groceries. He then exited and walked back through the car park towards his unit. Mr Brown appeared to be unsteady on his feet.
324. Between 6.24pm and 6.35pm, Ms McCoy attempted to call Mr Brown five times on his mobile phone and all calls went unanswered.
325. At 6.36pm, Ms McCoy called for an ambulance and indicated she was concerned about Mr Brown due to him starting on methadone and not answering his phone. Several phone calls ensued between Ambulance Tasmania, Tasmania Police and Ms McCoy.
326. Between 6.41pm and 7.07pm, Ms McCoy called Mr Brown a further six times without answer.
327. At 7.09pm, Ambulance Tasmania paramedics attended Mr Brown's address and observed no lights on in the unit and no answer at the door. Both Ambulance Tasmania and Tasmania Police radio room staff spoke to Ms McCoy. She further outlined her concerns and asked Ambulance Tasmania to break in but she was advised to return home from work to check on Mr Brown.
328. At 7.36pm, Ms McCoy returned home and found Mr Brown unresponsive on the floor of the unit. She called for an ambulance and commenced CPR. Attending paramedics could not resuscitate him and Mr Brown was declared deceased.
329. Police officers attended and conducted a search of the property where 6 x 60mg empty bottles of methadone, prescribed to Mr Brown were located and seized. The empty takeaway bottles were labelled with the dates 24, 25, 27, 28, 29 and 30 September 2016. Other drugs and medication (including cannabis, diazepam and Lyrica) and drug paraphernalia were located throughout the residence and were seized.

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285 NB1.

## Cause of Death

### Reported toxicological ranges: tolerance and postmortem redistribution generally

330. In interpreting the toxicological results, the concepts of tolerance and postmortem redistribution warrant discussion.
331. Postmortem concentrations of methadone and other substances are notoriously difficult to interpret, both because of an individual's tolerance to those substances and the phenomenon of postmortem redistribution.<sup>286</sup>
332. There was expert evidence at inquest, including from experienced forensic toxicologist Neil McLachlan-Troup and the various forensic pathologists, explaining these matters, and giving evidence about the reliability of the toxicological results with regard to the concepts. They are certainly relevant to interpretation of the toxicological results for all four deceased and hence must be allowed for in attempting to ascertain the amounts of methadone and other specified substances taken by each deceased and therefore the role played by those substances in their respective causes of death.
333. Regarding the concept of tolerance, Mr McLachlan-Troup stated in one of his reports:

*“With repeated use of the same drug, tolerance can develop to the side-effects and sometimes the therapeutic effects of drugs, and so larger and/or more frequent dosing may be required to produce the same pharmacological effects. Consequently, therapeutic blood levels in tolerant individuals could greatly exceed reported therapeutic ranges. Not only may tolerance develop to the drug being used but so may cross tolerance to structurally similar drugs. Therefore, a tolerant individual may exhibit few signs of impairment with a drug blood level which might be considered toxic or even lethal to an intolerant individual. Should an individual omit doses or increase the dose, then this irregularity in the dosing regimen may prevent the development of pharmacological tolerance and so the possibility of drug impairment remains.”<sup>287</sup>*

334. The risk of excessive sedation is potentiated if taken intermittently in excessive doses due to the lack of underlying tolerance.<sup>288</sup>

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286 G1A report of Dr Jonathan Brett, page 4 and 8.

287 G33(f).

288 G 1A report of Dr Jonathan Brett 11 May 2018, page 6.

335. Mr McLachlan-Troup was questioned at length and gave evidence of the difficulty and variables applying to placing a description of “apparent effect” on drug concentrations for tolerant individuals.<sup>289</sup>

336. In relation to postmortem redistribution, there was evidence at inquest that there are particular reasons why the reported levels of methadone taken from postmortem blood samples analysis may not be an accurate reflection of the probable level before death.

337. However, he explained that his toxicology reports attempt to explain the variables by using the qualifying words that the results are:

*“based on current literature and the principal indications of a drug, if taken in isolation. The effect may not be appropriate for all individuals particularly those with significant pharmacological tolerance, or when drug is taken in addition to other drugs/alcohol. In addition, the clinical effects for many drugs do not correlate well with blood concentration.”<sup>290</sup>*

338. After death, the blood concentration of many drugs is affected by postmortem redistribution through the vascular system from the major organs by direct postmortem diffusion from organ to organ, and sometimes by incomplete distribution. Sedimentation of blood after death may also affect the blood concentration obtained.<sup>291</sup> In other words, the methadone contained in the organs frees into the blood and therefore produces, on toxicological analysis, a level that may be higher than the blood level when the person was alive.<sup>292</sup> Reported blood concentrations can also vary in accordance with the site from which the sample was taken.<sup>293</sup>

339. There would appear to be a case against forensic laboratories reporting concentration levels of drugs prone to significant postmortem redistribution. Dr Ritchey gave evidence that, if it was “*up to him*” the laboratory scientists would not include apparent effect of a particular drug if taken alone, nor the description of the range – for example “*therapeutic*,” “*toxic*” or “*fatal*” ranges – because the amount analysed in the blood may not reflect what was in a person’s blood stream at the time they died. These reported ranges are based on the effect upon living people. Dr Ritchey’s evidence was that, despite the

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289 T920.

290 See for example, CMW7.

291 G33(e) Drug Abuse Handbook.

292 T104 Dr Donald Ritchey.

293 G33(e) page 7.

significant issues with quantification of drug concentrations, stating  
*“nonetheless, those are the ranges we have to deal with...”*<sup>294</sup>

340. In the final analysis, postmortem toxicology results must be interpreted with regard to all of the available information, including medical history, information from the scene, autopsy findings, the nature and exact location of the postmortem samples collected, and the circumstances of the death. Only after weighing these variables can postmortem results be reliably interpreted. Even then, reliable interpretation of some results is simply not possible based on the available information.<sup>295</sup>
341. Upon the evidence, I do not consider that the reporting of the postmortem levels and apparent effect of substances in the system of a deceased person is worthless in an evidentiary sense; and that there is reason for the information still continuing to be reported in toxicology reports. It is clear, however, that the results must be interpreted with caution and against all surrounding evidence.
342. A particularly important point in interpretation of toxicological results, which will be discussed later, was that made by Dr Ritchey in evidence:

*“It’s not just the presence of the drug, nor the amount that’s there, although it is an important piece of information, but rather it is the combination of drugs that are present that make the big difference in a case such as this.”*<sup>296</sup>

343. Counsel assisting, in closing submissions, also accurately summarised some of the complex and variable factors affecting tolerance, including the concurrent use of other sedative or CNS depressants, physical health and the concept of cross tolerance.<sup>297</sup>

#### Mr Brown’s cause of death

344. Dr Christopher Lawrence, State Forensic Pathologist, performed an autopsy on Mr Brown. He observed scars on the right and left antecubital fossae (inside the elbows), consistent with old injection marks, recent needle marks on the right thumb and on the right first finger with a healing needle mark on

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294 T105. See also the evidence of Neil McLachlan-Troup.

295 G33(e).

296 T105 (verbal fillers and disfluencies removed from quote).

297 Closing submissions of counsel assisting dated 7 November 2024.

the right wrist; and healing abrasions on the left forearm.

345. A toxicology report was prepared by Forensic Science Services Tasmania (FSST) which indicated that Mr Brown had methadone in his system in the reported toxic/fatal range, diazepam in the reported therapeutic range, and methamphetamine in the low range. THC (the active ingredient of cannabis), caffeine and nicotine were also detected.
346. Dr Lawrence opined that the cause of Mr Brown's death was combined drug (methadone and benzodiazepine) intoxication. In Dr Lawrence's view, he had probably injected methadone and may have also injected methamphetamine. Dr Lawrence commented in his report that benzodiazepine potentiates the effect of methadone and that injection itself increases the respiratory depressant effect of methadone. The effect of a low level of methamphetamine was unclear.
347. A question arose in the case of Mr Brown regarding whether he developed tolerance to methadone from the time he was released from prison. Mr McLachlan-Troup said in evidence that a "steady-state level" equivalent to being tolerant usually occurs in three to seven days. He said that the signs of lack of tolerance would be those of classical CNS depression, being drowsiness, slurred speech or staggering gait and signs of that type.<sup>298</sup> He suggested, however, that others may have greater expertise in this field.<sup>299</sup>
348. As discussed under the previous heading, the concept of tolerance is complex and involves the interplay of many variables.<sup>300</sup> In Mr Brown's case, his clearly witnessed "classic" signs of being under the influence of CNS depressant drugs militates against a finding of tolerance.
349. Further, the dosage and amount of methadone provided to him by Dr Jackson (and possibly by others) was significant. It is trite to say that there is a vast difference between the usual starting dose of methadone, 5mg-20mg, and the 60mg doses Mr Brown was prescribed. Additionally, the takeaway doses were intravenously injected and taken with benzodiazepines- further reducing tolerance.
350. I accept the expert evidence regarding the potential for a degree of cross-

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298 T 886.

299 T 886.

300 T2393 In his evidence, Dr Jackson also acknowledged the complexity of the issue of tolerance.

tolerance from his prison-prescribed buprenorphine acting upon the same opioid receptor in the brain.<sup>301</sup> However, the evidence far from persuades me in Mr Brown's case that he had tolerance to high doses of intravenous methadone would be achieved following controlled dosing with buprenorphine in the prison setting.

351. I find, upon all of the evidence, that Mr Brown did not have tolerance to the prescribed methadone following his release from prison.
352. Dr Johan Duflou, a forensic pathologist retained by the pharmacists, reviewed the autopsy report and agreed with Dr Lawrence's conclusions regarding Mr Brown's cause of death.
353. There is no controversy about the cause of death in Mr Brown's case. However, counsel for Dr Jackson submitted that Mr Brown may not have died as a result of the methadone takeaway doses prescribed by Dr Jackson and dispensed to Mr Brown. Counsel for the pharmacists made the same submission with a well-reasoned analysis of the drug items present at the scene:

*"The identity of the source of the drugs that caused Mr Brown's fatal toxicity is a matter of mere conjecture, guesswork or surmise between equally probable sources. It therefore is not open to find which drugs from which sources caused the fatal toxicity."*<sup>302</sup>

354. In her closing submissions, counsel for the pharmacists submitted that the number of methadone bottles, being takeaway doses, found by investigators at the scene was confusing. However, I am fully satisfied from the clear content of affidavits made very early in the investigation that, at the very minimum, six empty 60mg methadone takeaway bottles prescribed to Mr Brown were found by detectives and which were respectively labelled with the dates 24, 25, 27, 28, 29 and 30 September 2016.<sup>303</sup> In her affidavit made 12 days after Mr Brown's death, Detective Lowe summarised the primary drug evidence in her search – *"a large quantity of empty methadone bottles prescribed both to N Brown and M Bannister (McCoy). I also observed numerous empty packets of prescription medication including Lyrica, Valpam,<sup>304</sup> Subutex and Diazepam*

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301 T1101, evidence of Dr Brett and T888, evidence of Mr McLachlan-Troup.

302 Pharmacists' closing submissions, page 24.

303 NB45 Affidavit of Detective Claire Lowe.

304 Brand name for the benzodiazepine diazepam.

*and a small amount of cannabis, and needles.*<sup>305</sup>

355. Counsel for the pharmacists, Ms Walsh, pointed to another methadone takeaway dose at the scene in the name of Wayne Leary (Ms McCoy's uncle). She also submitted that drugs and drug packaging at the scene were photographed in ways that meant there was difficulty matching them against the property receipts.
356. At inquest, the exercise of reconciliation of the drug exhibits at the scene with the property seizure receipts was undertaken by Ms Walsh with attending officers. Despite what I considered to be a relatively thorough cataloguing of the exhibits, there was some uncertainty regarding the totality of the drugs and drug paraphernalia at the scene. I have full regard to Ms Walsh's thorough submissions in closing on this point.<sup>306</sup>
357. It is very clear, however, that Mr Brown's recently prescribed takeaway doses of methadone, including doses for future days after his death occurred, were at the scene and empty.
358. Ms Walsh submitted that Mr Brown may well have consumed other drugs and methadone from different sources that was not apparent from the scene.
359. On this issue, counsel assisting submitted:
1. To suggest that because the exact combination of drugs that contributed to Mr Brown's death is unknown means that I cannot be satisfied that the drugs prescribed by Dr Jackson on 22 and 26 September were causative of death, ignores settled principles of the law of relating to causation in coronial inquests.
  2. The drugs in Mr Brown's body included high doses of methadone and benzodiazepines as well as lower amounts of methamphetamine and cannabis.
  3. Dr Jackson prescribed significant takeaway doses (seven doses of methadone at 60mg per dose and at least 50 x 5mg diazepam tablets).
  4. At the scene, six used methadone bottles prescribed and empty blister packs were found at or shortly after time of death.

5. There is no evidence that he used other drugs and, whilst this possibility cannot be totally discounted, it is speculative and not supported by evidence either in the toxicology screen or evidence of his partner, Ms McCoy, who had little reason to lie about this.
  6. There is little to no basis to suggest that the methadone and diazepam prescribed by Dr Jackson was not used (probably by injection) by Mr Brown. It is inherently implausible that Mr Brown would invent a story for Dr Jackson in order to obtain multiple takeaway doses of a drug he was not even previously using, if he didn't intend to take those doses or if he already had enough on hand.
  7. Whilst it is not certain that the drugs prescribed by Dr Jackson, discussed with Mr Jacometti and dispensed by Mr Nash and Ms Cook were the only drugs he used (in that it is possible he also used other sources of methadone or benzodiazepine), a finding should be made on the balance of probabilities that Mr Brown used most, if not all, of the drugs that were prescribed and therefore that their consumption was a substantial contributory cause of his death.
360. I fully accept counsel assisting's logical reasoning. It is clear upon the evidence, and I find, that Mr Brown injected his takeaway methadone doses prescribed by Dr Jackson, or a substantial quantity of them. I also find that he ingested an unknown quantity of diazepam prescribed by Dr Jackson. The methadone and diazepam were wholly or substantially causative of his death.

### *Conclusions regarding Mr Brown's death*

361. It is appropriate to set out in full the conclusions expressed by Dr Brett in respect of Dr Jackson's treatment and prescribing to Mr Brown, as it pertains to the circumstances surrounding his death.
362. I accept Dr Brett's opinions in full and, as discussed above, Dr Brett's evidence at inquest was clear, logical and credible. Whilst his expertise was impressive, I did not at any time gain the impression that his opinions were based upon unrealistically high standards.
363. Dr Brett reported as follows:<sup>307</sup>

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307 G1B at pages 3-5. Capital letters used for surnames removed for ease of reading.

*"I note issues identified in my initial report included;*

*1. (i) it is (and was in 2015/16) standard practice to prescribe suboxone unless a valid reason (e.g. intolerance to suboxone) is otherwise documented. This is because the naloxone component of suboxone reduces the ability to inject this formulation. This also reduces the appeal to divert this medication.*

*(ii) Dr Jackson was aware that NB was injecting his Subutex after being informed by Dr A.McKinlay on 28th June 2016. Injection of buprenorphine causes higher peak concentrations and increases the risk of overdose, particularly when occurring in combination with benzodiazepines.*

*2. Dr Jackson continued to prescribe take away doses while possessing information clearly indicating NB was unstable on his opioid substitution treatment (OST) program. An understanding of patient stability is fundamental to planning for treatment on an opioid substitution program due to the risks or death and associated harms with instability and the impact treatment decisions can have. Features of instability exhibited by NB include:*

*(i) Extra-medical use of Subutex including injection*

*(ii) Unstable and high dose benzodiazepine use*

*(iii) Significant harms related to benzodiazepine use including intoxication documented on multiple occasions and leading to his removal from the Bridge Program and intentional overdose with benzodiazepines on 23rd May 2015.*

*(iv) Evidence of drug seeking behaviours in the form of repeatedly reporting prescriptions or medicines lost or stolen. Dr Jackson eventually became aware of this and instituted controlled dispensing of diazepam with NBs Subutex on 29th July 2015 but only for one dispensing and only after several incidents indicative of drug seeking behaviours.*

*(v) Intentional self-poisoning on 23rd May 2015.*

*(vi) Release from prison on 22nd September 2016: By definition, I would consider anyone released from prison is unstable as this is a high-risk period for overdose and death amongst people with a history of opioid dependence.*

*I note that Dr Jackson regularly prescribed three take away doses per week. In addition, he regularly authorised additional take away doses. These practices were flagged to PSB as concerning by a dispensing pharmacist on 1st February 2016 and records indicate that NB had up to 20 take away doses of Subutex (Jan 2016) per occasion of dispensing. It is usual practice to verify the reasons stated by the patient for requiring additional take away doses such as travel tickets or contact with hospitals in the case of visiting sick relatives. There is no indication of this having occurred in this case.*

*It is my opinion that with knowledge of features of clinical instability, ongoing prescription and non-prescribed authorization of take away doses of subutex initially and then methadone, constituted a breach of State Policy (TOPP) and poor and unsafe clinical practice.*

*3. Dr Jackson breached State Legislation twice when prescribing first Subutex and then methadone without an authority to do so from PSB. There were system failings to detect this issue. It is also the responsibility of the dispensing pharmacy to check whether authority has been granted by PSB before dispensing opioid substitution medication (buprenorphine or methadone). Records should be maintained within an OST practice of such authorization. Any registered nurses involved in the care of patients on opioid substitution therapy (OST) should also take responsibility to ensure that the correct authorization has been obtained.*

*4. Even with the knowledge that NB was unstable, Dr Jackson continued to prescribe ongoing high dose benzodiazepines without:*

*(i) controlled dispensing for most of the duration of this therapy*

*(ii) a treatment plan for this or a plan to taper this therapy over time*

*This constitutes also constitutes unsafe and poor clinical practice in my opinion.*

*5. Dr Jackson failed to appropriately review and document clinical assessments and management plans while engaging in higher risk prescribing.*

6. *There were issues with communication between a number of agencies, including:*

*(i) Between the hospital and Dr Jackson following NBs intentional overdose*

*(ii) Between the prison and Dr Jackson following release from prison*

*(iii) Between dispensing pharmacies and Dr Jackson to verify pharmacist's assessment of the patient on presenting for OST dosing and consistency of dosing history.*

*7. It is extremely concerning that Dr Jackson did not verify that NB had been switched from Subutex to methadone on release from prison and took the patient at face value given the evidence presented above. At the very least, last dose details of OST should have been obtained from the prison before continuing to prescribe OST. In the absence of this information, it would not be safe to prescribe methadone 60mg with three take away doses. Equally concerning is that Dr Jackson also prescribed diazepam on NBs release from prison without checking whether this had been continued in prison. Methadone is more sedating than buprenorphine leading to a higher risk of overdose when used alongside other sedatives such as benzodiazepines. A loss of tolerance to benzodiazepines and then consumption along with methadone contributed to NBs death in my opinion.*

*8. There is evidence from statements given by M.McCoy and police attending the scene of the death that NB had injected methadone and that these were likely to be his take away doses dispensed within the last week. There was also evidence of other empty methadone bottles labeled with other names (not M.McCoy or NB). This may indicate methadone obtained from diverted sources. Methadone is well known to be bought and sold illicitly.*

*8. There is evidence from the interview with N.Azon-Jacometti of an insufficient understanding of the TOPP in relation to safe processes around OST and patient stability as well as a deferral to Dr Jackson for all prescribing decisions. This is salient as it appears that Dr Jackson was relying heavily on information obtained from N.Azon-Jacometti during clinical assessments of NB and other patients rather than reviewing the patients himself. However, I acknowledge that this interview may have been a stressful process and may not best reflect N.Azon-Jacometti's's*

*clinical knowledge. While prescribing decisions are ultimately the responsibility of the prescriber, systems in which there are checks and balances provided by other people (such as registered nurses) or agencies (such as pharmacies) involved in delivering OST [ORT] are critical for OST to be delivered safely.”*

364. In his oral evidence at inquest, Dr Brett explained that he would have prescribed Mr Brown Subutex in continuation of his prison pharmacotherapy. However, he would have prescribed a significantly lower dose of Subutex following his release from prison if he was unsure of the last dosage. He said that he would have made “every effort” to independently confirm the relevant information with the prison, describing the risks of prescribing the incorrect type and dosage of opioid replacement.<sup>308</sup>
365. He further said in evidence that he could “say *with certainty*” that there was a real overreliance on Dr Jackson’s part on patient report. He went further and testified that, to prescribe as he did, there was a lack of understanding that patients might lie, and such reliance without verification was a dangerous practice.<sup>309</sup>
366. Counsel for Dr Jackson, in his closing submissions, did not specifically address each of the deficiencies described by Dr Brett above. Dr Jackson did not, as already discussed, consider that there were deficiencies. His counsel submitted:

*“He regrettably accepted the lies put to him by Mr Brown and Ms McCoy, to ensure that Mr Brown had necessary medication to treat his addiction, based on what was told to him by Mr Brown and Ms McCoy. He regrets that he accepted their false narrative of traveling away from Hobart to Cradle Mountain and then subsequently Mr Brown having to travel urgently to Queensland to attend to his daughter who had been in a motor vehicle accident. Mr Jackson accepts that he was duped by Mr Brown and Ms McCoy and deeply regrets that that occurred.”<sup>310</sup>*

367. It is clear, however, that Dr Jackson maintained his view that he was largely entitled to believe his patients without verifying their accounts, the verification process being demeaning to them. It does not seem likely to me that, if Dr

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308 T1010-11.

309 T1103.

310 Closing submissions counsel for Dr Jackson, paragraph 87.

Jackson was faced with the same situation again, he would not change his approach or act any differently or more diligently.

368. There was significant evidence about whether Dr Jackson made any or any proper attempt to contact the prison before prescribing methadone to Mr Brown to verify his prison medication. If he did not, it was a gross breach of his duty to his patient.
369. His counsel stated in closing that Dr Jackson “*gave evidence that he attempted to establish the treatment regime for Mr Brown through the prison authorities but was unable to get information.*”<sup>311</sup>
370. At inquest, Dr Jackson suggested he tried to contact the prison to confirm Mr Brown’s prescription but received no response. However, I reject Dr Jackson’s evidence that he made any or any sufficient attempts at all to contact the prison to verify the opioid pharmacotherapy provided to Mr Brown whilst incarcerated. In his comprehensive 2017 affidavit there is no mention of attempting to contact the prison.<sup>312</sup> Like much of Dr Jackson’s evidence at inquest, his answers on this topic were confusing and contradictory (perhaps intentionally), and replete with instances of re-invention and justification.<sup>313</sup>
371. There is no record of contact from the prison and no record in Dr Jackson’s mobile phone records. He said that he could not remember where he was or what phone he used and confirms he did not try any other method of contact such as fax or email.<sup>314</sup> When asked why he did not write to the prison at any stage, he said he suspected he was “*just too busy.*”<sup>315</sup> He confirmed that he had no information from the prison.<sup>316</sup>
372. Dr Jackson indicated that usually a patient was given enough medication by the prison to last a couple of days until they could arrange a consultation with their prescribing doctor. He was unable to explain why, if this was the case, he was so urgently prescribing Mr Brown with methadone without waiting for an authority from PSB. He suggested Mr Brown was not provided with the prison medication on this occasion, but when asked how he knew this, he initially suggested that he had a vague recollection of calling the pharmacy to confirm

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311 Closing submissions of counsel for Dr Jackson-paragraph 86.

312 NB13.

313 For example, T2788.

314 T2784-5.

315 T2788.

316 T2781-2.

whether a prescription had been received from the prison. I do not accept his evidence that he even considered calling the pharmacy for such information.

373. Dr Wake<sup>317</sup> indicated that if a doctor called the prison during business hours to request information regarding a prisoner they were treating, they would initially be answered by administration and then the call would go to him. Outside business hours, they would be answered by a nurse but again the request would go to him for follow-up, possibly by email.
374. Dr Wake confirmed that if a doctor was to call about a patient, there would invariably be a record with himself, the nurses or the prison pharmacy; and if he received a request for prescribing information relating to a specific patient from their doctor, he would write a short discharge summary.
375. Dr Wake gave evidence that a similar result would occur if a pharmacist wanted to discuss a patient's prescription. He was not aware of any significant difficulties in the prison providing such information when requested, and said that the prison pharmacists are highly interactive.<sup>318</sup>
376. I perceived Dr Wake's frank and knowledgeable evidence on this point to represent what is far more likely to occur when a medical practitioner makes contact with the prison about the important issue of medications to be prescribed upon release; that is, the prison provides timely and responsive communication in reply.<sup>319</sup>
377. I find that Dr Jackson made no attempt to contact the prison. He vacillated and speculated about the manner and timing of his attempted contact, but I did not find this evidence to be truthful. It seemed that he invented his answers as questions were put to him to appear he had discharged an obvious and important duty to his patient.
378. I will deal later with the broader issue of communication with the prison and information exchange regarding treatment and release of prisoners.
379. In conclusion, I find that Mr Brown died unintentionally of drug toxicity. He

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317 Head of Department of Correctional Primary Health Services.

318 T1428.

319 See the evidence of Jerry Hampton, experienced pharmacist, who described difficulties receiving pharmaceutical information in respect of prisoners. However, He gave evidence consistent with Dr Wake that the information from the prison had improved significantly by the time of Mr Brown's incarceration; and it was not then difficult for a pharmacist to obtain pharmaceutical information: T1341.

voluntarily ingested a number of drugs, principally by injecting a quantity of methadone from takeaway doses prescribed to him by Dr Jackson.

380. Mr Brown, with Ms McCoy, duped Dr Jackson into supplying the methadone, including multiple takeaway doses, by giving him patently false information. Over three separate prescribing events, Dr Jackson placed Mr Brown in danger by prescribing the methadone without verifying Mr Brown's recent prison prescriptions or even seeing him to assess his condition and risk. He was also grossly in breach of his duty as a doctor and the TOPP guidelines in numerous other respects as described.
381. Mr Jacometti played a part in facilitating the prescriptions, when he ought to have known of the risks to Mr Brown without verification of prescribing history and proper assessment for stability. He went as far as improperly requesting the pharmacy to prescribe methadone to Mr Brown, when he did not have any right to do so.
382. If Dr Jackson had not supplied methadone to Mr Brown, it is likely that he would not have died at that time.
383. Ms McCoy, herself drug dependent, encouraged Mr Brown to seek methadone from Dr Jackson. Her actions showed little regard for Mr Brown's safety. On the day of his death, she was aware that he injected a methadone takeaway dose and was very concerned about his groggy state before she went to work in the afternoon. She would well have known of his lowered tolerance to methadone at this time. She had no legal duty to do any more to assist him and Mr Brown could have sought medical attention during the day. Nevertheless, earlier intervention by Ms McCoy may have resulted in Mr Brown being hospitalised with a chance of life-saving treatment.

## **Toni Lee Wiki**

### *Background*

384. Toni Lee Wiki was born on 10 August 1978 in Nelson, New Zealand to Gillian Fowler and Michael Thomas Wiki. She was the eldest of two daughters, and had a half-brother and half-sister. In 1980, at two years of age, Ms Wiki and her family moved to Eden in New South Wales. The family lived in Eden for 10 years, before Ms Wiki's parents separated, and then Ms Fowler moved with Ms Wiki and her sister to Hobart. Ms Wiki had very little contact with her father from this point onwards.

385. As a child, Ms Wiki was generally healthy. She attended Eden Primary School until the move to Tasmania in 1990, where she then attended Campbell Street Primary School. Ms Fowler described her daughter as enjoying school and being quite clever.
386. Ms Wiki then attended Ogilvie High School. Ms Fowler said that she was quite social and able to make friends easily. Ms Wiki briefly attended Elizabeth College before leaving halfway through her first year.
387. She worked casually as a bartender in the late 1990s but was in receipt of government benefits for most of her life.
388. In 1995, Ms Wiki entered a relationship with Shane Little. Together, they moved to Sydney where they had two daughters together. They are Skye Little, born in 1997, and Chelsea Little, born in 2000.
389. Whilst in Sydney with Mr Little, Ms Wiki began to use illicit drugs, specifically morphine and heroin. Her health then started to deteriorate. Ms Fowler also said in her affidavit that she thought Ms Wiki was suffering from postnatal depression after giving birth to her daughters.<sup>320</sup>
390. In about 2002, Ms Wiki moved back to Tasmania with her family. From this time onwards, she was treated with ORT by various medical practitioners. At various times, she attempted unsuccessfully to rehabilitate from her severe drug addiction.
391. In about 2004, Ms Wiki was diagnosed with anxiety and depression. That same year, Ms Wiki's relationship with Mr Little ended.<sup>321</sup>
392. Following the end of the relationship, her drug abuse considerably worsened. As a result of child protection intervention, Skye and Chelsea were removed from Ms Wiki and were made subject to state guardianship. However, they were placed in the full-time care of Ms Fowler and continued to spend time with their mother.
393. In 2005, Ms Wiki met Jared Tuffin. They subsequently moved in together and had a daughter, Layla Tuffin, born in 2007.
394. Ms Wiki and Mr Tuffin's relationship was described as "toxic" by her daughter,

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320 CTW22.

321 CTW19.

Skye, who swore an affidavit for the investigation.<sup>322</sup> Ms Fowler also described Mr Tuffin's alcohol abuse as causing Ms Wiki anxiety and unhappiness. She said:

*"Jared was a heavy drinker for the duration of their relationship. This made Toni very upset and anxious. It affected her lifestyle as Jared was controlling and wouldn't allow Toni to do anything with the girls unless he was there."*<sup>323</sup>

395. Mr Tuffin, like Ms Wiki, was an intravenous drug user.<sup>324</sup> The relationship was marked by were allegations of family violence against each other, some incidents resulting in the attendance of police. Ms Fowler recalled that Mr Tuffin was violent to Ms Wiki in front of her daughters when they had visits with their mother.
396. When Ms Wiki and Mr Tuffin separated in early 2015, they shared custody of Layla.
397. That same year, Ms Wiki formed a relationship with Martin Quigley. Ms Wiki would often stay with Mr Quigley at his unit on the nights Layla was staying with Mr Tuffin. Ms Wiki and Mr Quigley separated in December 2016 but continued to see each other intermittently until Ms Wiki's death in February 2017.
398. During late 2016 and early 2017, Ms Wiki worked to improve her health and mental state. She attended her sister's wedding in December 2016, and in January 2017 she appeared motivated and happy.<sup>325</sup>

### *History of drug use*

399. Sadly, Ms Wiki's life was affected by her long-term addiction to multiple drugs, including opiates, amphetamines, and cannabis.
400. In July 2002, Ms Wiki presented to Dr Emil Djakic at the Patrick Street Clinic in Ulverstone. At the time, Dr Djakic identified that Ms Wiki was an intravenous drug user and commenced treating her with ORT. Dr Djakic had received an authority from PSB to prescribe Ms Wiki buprenorphine sublingual tablets

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322 CTW22.

323 CTW19.

324 CTW22.

325 CTW19.

(Subutex) on the condition that all doses were to be taken under supervision, with no takeaway doses. Only weeks after commencing this treatment, Ms Wiki's prescription was cancelled, presumably because she had disengaged. She had no further contact with Dr Djakic or the Patrick Street Clinic.

401. On two occasions, being December 2002 and August 2005, Ms Wiki was a patient at the Alcohol and Drug Service in Hobart for opiate detoxification.<sup>326</sup> On the first occasion she chose not to complete the program after using morphine on a group outing; and on the second occasion, she left voluntarily to attend to legal problems.
402. Between July 2006 and March 2013, she was cared for by Dr Rajendra Prasad. During this time, she was being treated ORT and was prescribed methadone. The evidence indicates that Dr Prasad considered Ms Wiki to be generally compliant with her treatment, albeit there was some evidence that on occasions in 2008 and 2009 she tested positive for cannabis and unprescribed benzodiazepines. It would appear likely that Ms Wiki was still sourcing illicit substances throughout this period.
403. In March 2013, Ms Wiki's care and her ORT was transferred to Dr Shaunagh Jones. Dr Jones saw Ms Wiki on 28 March 2013 but did not have the capacity to continue with her care. Therefore, at the appointment, Dr Jones provided Ms Wiki with a six-week interim prescription for methadone 65mg daily.
404. On 8 May 2013, Ms Wiki attended the Hobart Clinic and saw Dr David Jackson, who agreed to take over her care. Dr Jackson was responsible for Ms Wiki's care and ongoing participation in ORT up until her death. During this time, Ms Wiki remained on methadone.
405. In August 2013, Dr Jackson increased Ms Wiki's methadone dose from 65mg per day with two takeaway doses per week to 70mg per day with three takeaway doses per week.
406. In March 2014, her dose was increased to 80mg per day.
407. On 8 December 2014, Ms Wiki told Dr Jackson that she was having troubles at home with Mr Tuffin, and that her daughters and was purchasing diazepam on the streets in order to cope. Dr Jackson subsequently began prescribing diazepam to Ms Wiki. It is unknown what dose was prescribed at the time as it

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326 CTW10a.

was not recorded in the notes. However, on 17 March 2015 a subsequent diazepam prescription was written for 1 x 5mg diazepam tablet three times per day, with the prescription to be dispensed weekly. Therefore, Ms Wiki was collecting 21 diazepam tablets on each occasion.

408. Just 10 days later, Dr Jackson increased Ms Wiki's methadone dose to 90mg per day with three takeaway doses per week.
409. On 16 August 2016, Dr Jackson increased Ms Wiki's takeaway doses to four per week and extended her prescription for three months.
410. In the days leading up to Ms Wiki's death on 14 February 2017, she received the following pursuant to Dr Jackson's prescriptions:
- On 8 February 2017, a supervised 90mg dose of methadone and collected 21 x 5mg diazepam tablets and one takeaway dose of methadone for the following day;
  - On 10 February 2017, a supervised 90mg dose of methadone and two takeaway doses of methadone; and
  - On 13 February 2017, a supervised 90mg dose of methadone and one takeaway dose of methadone.

#### *Circumstances surrounding the death of Ms Wiki*

411. By February 2017, Ms Wiki was living with Mr Quigley at Arthur Street, North Hobart.
412. Mr Quigley gave evidence that around this time both he and Ms Wiki were injecting their prescribed takeaway methadone doses.<sup>327</sup> He indicated that Ms Wiki was also injecting Xanax<sup>328</sup> at the time and taking other "benzos" orally. He said that she was additionally sourcing methadone from alternative (illicit) sources as well.
413. It was Ms Fowler's impression that, for some months before her death, her daughter looked well, was participating well on the methadone program, and did not appear to be using illicit drugs. Ms Fowler was aware that Mr Tuffin was on the methadone program and that Mr Quigley was a user of illicit drugs.

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<sup>327</sup> T1848.

<sup>328</sup> A brand name for the benzodiazepine alprazolam.

Nevertheless, she said that there were indicators that Ms Wiki was “getting her life back on track.”<sup>329</sup> Ms Fowler said that her daughter was “extremely excited” about the impending arrival of Chelsea’s baby.<sup>330</sup>

414. Mr Tuffin recalled seeing Ms Wiki on Monday 13 February 2017 at the pharmacy. His recollection was that she seemed relatively healthy and happy. They also spoke on the phone that evening.
415. Mr Quigley states that Ms Wiki was at his unit that evening. He said that she did not take anything unusual that evening but confirmed that she usually took multiple valium tablets orally each day.
416. To place the circumstances in some context, Mr Quigley had been declared drug dependent and was a heavy intravenous user of illicitly sourced drugs.<sup>331</sup> He was also a patient of Dr Jackson, who prescribed him methadone, including takeaway doses.
417. The criminal and coronial investigation incorporated a large body of evidence surrounding Dr Jackson’s treatment of and prescribing to Mr Quigley for the purpose of considering Dr Jackson’s non-compliant practices. However, following submissions from counsel, I ruled that the evidence specifically relating to Mr Quigley’s ORT managed by Dr Jackson should not be tendered as formal exhibits at inquest. Therefore, I specifically disregard this body of evidence in making these findings.
418. Mr Quigley swore two affidavits in 2017 for the investigation.<sup>332</sup> In those affidavits, he said little about Ms Wiki’s illicit drug use. Mr Quigley did not answer his summons to attend court to give evidence at inquest. I therefore made an order for his arrest, which duly occurred. Upon his presentation to court, I made a bail order for him to reappear to give evidence. Mr Quigley did appear and gave what I considered to be reasonably frank evidence regarding the circumstances of Ms Wiki’s drug use immediately before her death.
419. At 8.00am the following morning, 14 February 2017, Ms Wiki and Mr Quigley left their Arthur Street unit and returned at around 10.30am. Mr Quigley gave evidence that the purpose of this trip was to visit Shane Fazackerley to repay a debt to him of 100 dollars. He said that that they did not purchase any drugs

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329 CTW19.

330 Ibid.

331 CTW20.

332 CTW20 and CTW21.

from Mr Fazackerley that morning. Mr Fazackerley then returned to the Arthur Street unit with them.

420. Mr Quigley told the inquest that Ms Wiki had “saved up” a takeaway dose of methadone to inject for Valentine’s Day. He had purchased his own from elsewhere. He said that Ms Wiki was tolerant to high doses of methadone and, after being dosed at the pharmacy, she would inject two of her takeaway doses. He told the court that she would sometimes inject Xanax combined with methadone for additional “power.” However, Mr Quigley said that on the day of her death, she only had one of her prescribed takeaway doses and she injected it at 10.30am.<sup>333</sup>
421. He said that he was not aware that she took Xanax that morning. His recollection was that Ms Wiki was injecting into her neck at this time, as her other veins had collapsed. He even said that the veins in her neck were looking noticeable. Mr Quigley said that, before injecting, Ms Wiki would have a shower to prepare her veins.
422. On this particular morning, Ms Wiki was in the bathroom preparing equipment to inject herself. Mr Quigley was undertaking the same process in the lounge room and then left to go outside to have a cigarette. He gave evidence that he saw all Ms Wiki’s preparation but did not see her inject herself. I doubt this aspect of his evidence. It seems more likely that he was with Ms Wiki, possibly assisting her to inject.
423. Whilst outside the unit, he said, Mr Quigley heard Ms Wiki scream. He came back inside and saw her lying on the couch, unresponsive and vomiting. Ms Wiki was breathing but confused. He described her as being in agony, curled up in the foetal position.
424. At 11.30am, immediately after he found her in such a state, Mr Quigley called 000 for an ambulance. When paramedics arrived, they found Ms Wiki moaning in pain before she collapsed. The paramedics noted that, apart from Mr Quigley, who had made the 000 call, an unknown male was present at the scene believed by police to be Shane Fazackerley. It was, in fact, Mr Fazackerley.
425. Both paramedics at the scene provided affidavits that they were advised by one or both of the males at the scene advised that Ms Wiki had taken some

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333 T 1857-1858.

tablets earlier in the morning, being Valium and Xanax of an unknown quantity, and that she had started complaining of abdominal pain about half an hour prior to calling the ambulance.<sup>334</sup>

426. When paramedics could no longer locate a pulse, resuscitative efforts were commenced and Ms Wiki was transported to the RHH. She could not be revived and died at 12.26pm.
427. Tasmania Police officers conducted a search of the unit and located used syringes, several empty methadone bottles in Ms Wiki's name, a Xanax tablet and two empty bottles of diazepam.
428. After hearing all of the evidence, including that of Mr Quigley, Mr Fazackerley and the paramedics, I find that Ms Wiki injected a Xanax pill which she illicitly sourced.
429. I cannot find, however, who supplied her with the Xanax. I am hesitant to accept the evidence of Mr Quigley that he had no knowledge that Ms Wiki used Xanax. I also do not accept the evidence of Mr Fazackerley at face value that a drug transaction did not take place that morning. After being untruthful in his affidavit, Mr Tuffin said in evidence that he and Ms Wiki would inject Xanax together and he would source it illicitly. It is possible that he, too, may have supplied Ms Wiki with Xanax before her death.

### *Cause of death*

430. Dr Donald Ritchey, forensic pathologist, performed an autopsy upon Ms Wiki on 15 February 2017, and subsequently prepared a report.
431. At autopsy, Dr Ritchey observed that there were multiple recent needle punctures in the antecubital fossa (inside elbow) and dorsum of the right hand, which may have been reflective of medical intervention but were indistinguishable from intravenous drug use. He also observed additional recent needle puncture marks on her left foot, more consistent with self-injection, and healed linear transverse scars on the right forearm and wrist.
432. He also observed foreign body granulomatosis of the lungs, which was indicative of intravenous use of "crushed" pill fragments. Dr Ritchey also observed extensive anthracosis of the lungs, which was consistent with Ms

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334 CTW26 Affidavit of Carrie Burns and CTW27 Affidavit of Peter Cecys.

Wiki being a smoker.

433. Toxicological analysis of Ms Wiki's postmortem blood samples revealed the presence of methadone within the reported fatal range; alprazolam (Xanax) within a high therapeutic range; diazepam within a therapeutic range; and THC (the active constituent of cannabis).
434. Dr Ritchey, in his report, determined that the cause of death was primarily mixed prescription drug toxicity. However, he found that a significant contributing factor was the diffuse foreign body granulomatosis of the lungs caused by intravenous drug use.
435. The court also received evidence about Ms Wiki's cause of death from Dr Duflou.
436. Dr Duflou provided a report in respect of Ms Wiki, dated 4 November 2022.<sup>335</sup> His opinion was that the cause of Ms Wiki's death was acute cardiovascular collapse due to intravenous injection of insoluble tablet excipients in the setting of pre-existing extensive pulmonary intravascular foreign body granulomas.
437. Dr Ritchey provided a further report on 5 April 2023 following Dr Duflou's review.<sup>336</sup> He revised his opinion with the benefit of receiving evidence regarding the signs and symptoms displayed by Ms Wiki in the minutes prior to her death.
438. On the basis of Ms Wiki's presentation at that time, Dr Ritchey agreed that acute heart failure was the primary cause of death due to foreign body granulomatosis caused by intravenous drug use. However, he adhered to his view that mixed prescription drug toxicity was contributory due to Ms Wiki's drug dependence/drug seeking and also central nervous system depression complicating resuscitation.
439. Dr Ritchey, in evidence, explained the formation of granulomatosis. He said that microcrystalline cellulose, effectively refined wood pulp, goes to binding a pill into a "*nice tablet*." He explained that this substance is completely insoluble in water. Even when crushed into a solution for injection, the binding substance becomes trapped in the small blood vessels of the lungs. He

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<sup>335</sup> G37g Duflou Report – Wiki.

<sup>336</sup> G38c Dr Ritchey Affidavit 5.4.23.

explained that when the bodily processes attempt to remove or break down the trapped substance there is an inflammatory response which causes mass lesions that impair the flow of blood through the vessels. The heart is then required to working hard to push blood through the lungs, which results in cor pulmonale, being right-sided heart failure.<sup>337</sup>

440. Dr Duflou gave evidence in respect of his report on 23 May 2023, to the following effect:

- a. Cardiac arrest, rather than respiratory arrest, was the primary cause of death based on the history and observations of the ambulance officers. Paramedics had not observed difficulty breathing, which would typically be observed with an overdose of opioids.<sup>338</sup>
- b. Dr Duflou explained that the foreign body granulomas were causative of cardiac arrest due to blockages in blood vessels. This issue results in symptoms of abdominal pain where there are blockages to the blood pumping from the liver and other parts.<sup>339</sup>
- c. He disagreed with Dr Ritchey about the relevance of any CNS depression arising from the injected methadone. In his view, the effects of CNS depressant substances were not contributory to Ms Wiki's death.<sup>340</sup>
- d. Dr Ritchey and he were in agreement about the revised primary cause of death.<sup>341</sup>
- e. He characterised the granulomas as "very severe."<sup>342</sup>
- f. Dr Duflou's opinion was that Ms Wiki's presentation immediately prior to her death; vomiting, disorientation, lack of responsiveness was consistent with the primary cause of death he proffered. In his view, the presentation was not evidence of drug toxicity *per se*. He attributed the distress to pain she was in and indicated that vomiting was not uncommon in cases of cardiac events.<sup>343</sup>
- g. Dr Duflou maintained that CNS depressants would not have an impact on

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337 T2107.

338 T1950-1.

339 T1952.

340 T1952.

341 T1956.

342 T1990.

343 T2014-5.

cardiac resuscitation such as adrenaline or shocks.<sup>344</sup>

441. Dr Ritchey gave further evidence on 24 May 2022. In summary, he said:
- a. Ms Wiki's presentation - screaming, rolling around, disorientation, breathing but not responding and vomiting - was consistent with acute pain and his revised view that death occurred as a result of injecting crushed pills.<sup>345</sup>
  - b. That he maintained his view that CNS depression would have complicated resuscitation.<sup>346</sup>
  - c. Ms Wiki would not have been suffering from decompensated heart failure without drug dependence and drug seeking behaviour.<sup>347</sup>
442. Upon the expert evidence, the primary cause of Ms Wiki's death was cardiac arrest as a result of foreign body granulomas caused by injecting one or more crushed Xanax pills.
443. Ms Wiki's long-term drug dependence and abuse clearly resulted in her sourcing Xanax for intravenous injection and was responsible for the existing damaged state of her lungs. Further, I accept Dr Ritchey's evidence that her respiratory depression associated with methadone and benzodiazepine toxicity would have had the potential to hamper resuscitation. This proposition makes plain sense. However, upon the evidence, there appeared to be little likelihood of resuscitation, given the overwhelming severity of the fatal event.
444. Therefore, in the case of Ms Wiki, the primary cause of death is not related to her prescribed methadone or diazepam. I find therefore that the effects of methadone and benzodiazepine toxicity (as CNS depressants) cannot be found to be contributory in any more than a speculative manner or remoter way to the medical cause of death.

### *Conclusions regarding Ms Wiki's death*

445. As a preliminary comment, I observe that the benefit of a public inquest in appropriate cases is that issues are explored with the benefit of additional evidence and expertise. In the case of Ms Wiki, I have had the benefit of

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344 T2016.

345 T2092.

346 T2091-3.

347 T2093.

evidence from witnesses to the events surrounding her death and evidence from two forensic pathologists. The inquest process has caused me to find, differing from Dr Ritchey's original opinion, that Ms Wiki's cause of death was not due to drug toxicity causing respiratory depression.

446. Secondly, whilst the evidence does not establish a sufficient nexus between Ms Wiki's death and the prescribing by Dr Jackson, some limited comment is appropriate about the investigation.
447. As would be seen from the above narrative of Ms Wiki's drug addiction and medical treatment, considerable investigation has taken place surrounding this issue, with a particular focus upon Dr Jackson's prescribing to Ms Wiki since he commenced treating her in 2013. This, of course, was based upon mixed drug toxicity being the cause, or a significant cause, of death.
448. It is relevant, however, that Dr Jackson maintained his same unsafe manner of prescribing in respect of Ms Wiki as for the other deceased. The consistent issues, which were breaches of the TOPP guidelines, included insufficient consultations and assessments, lack of drug screening, prescribing takeaway doses in circumstances of clinical instability, and co-prescribing benzodiazepines with methadone.<sup>348</sup>
449. When Dr Jackson first saw Ms Wiki in 2013, he prescribed her methadone (a significant dose of 65mg) without first having obtained an authority from PSB.<sup>349</sup>
450. Relevantly, there appears to be no evidence that Dr Jackson made the necessary enquiries with Ms Wiki's previous medical practitioners, Dr Jones or Dr Prasad, prior to commencing her on methadone. He also prescribed three takeaway doses, contrary to the TOPP guidelines which specify that takeaway doses should not initially be prescribed. He continued throughout the remainder of Ms Wiki's life to prescribe her takeaway doses of methadone when Ms Wiki was not clinically stable and was abusing benzodiazepines. His response to Ms Wiki's abuse of illicitly sourced benzodiazepines was to commence prescribing her the same drug. Prescription of diazepam alongside methadone without documentation of a longer-term management plan or attempts to wean diazepam is unsafe and increases the risk of overdose and

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348 G1B Dr Brett report.

349 CTW16j PSB report. Dr Jackson gained the authority to prescribe methadone a short time later.

death.350

451. Dr Jackson increased Ms Wiki's methadone dose to the high dose (90 mg) prescribed as at her death; together with four takeaway doses per week. In 2016, Dr Jackson prescribed Ms Wiki an average of 17 takeaway doses per month, an excessive quantity given her level of instability.
452. Even when Dr Jackson was told that Ms Wiki was specifically injecting Xanax, this fact did not cause him to curtail her access to methadone (including takeaway doses) or benzodiazepines, nor did it seem to compel him to conduct more intensive or more frequent assessments of Ms Wiki including drug screening, checking for needle marks or probing her life circumstances.
453. In summary, the investigation into Ms Wiki's death so far as it inquired into Dr Jackson, confirmed that the manner in which he practiced pharmacotherapy was consistently unsafe and in breach the TOPP guidelines over a period of four years, and continued notwithstanding the death of Mr Brown in September 2016.
454. As it has emerged, the lack of sufficient connection between Ms Wiki's death and Dr Jackson's unsafe prescribing, has meant that further analysis of these issues is unwarranted. However, as mentioned, his practices in treating Ms Wiki are relevant to corroborate his approach in respect of the three other deceased.

## **Belinda Emma Kemp**

### *Background*

455. Belinda Emma Kemp was born on 28 March 1980 in Hobart to Kenneth Kemp and Gayle Kemp. She has one sibling, Jason Kemp. As a child, the family spent time living in Victoria whilst her father was a member of the RAAF. Upon his discharge from the RAAF in 1986, the family returned to Tasmania, settling in Gagebrook. Ms Kemp's parents separated in 1989. She resided with her mother, whilst her father moved to Brisbane in 1993. Ms Kemp attended Claremont High School until grade 10.
456. In about 1997, Ms Kemp moved to Melbourne and commenced a relationship with Timothy Gueran. They had three daughters together, Samantha Gueran,

born in 1998; Lisa Gueran, born in 1999; and Rebecca Gueran, born in 2004. Ms Kemp and Mr Gueran subsequently separated.

457. In 2007, Ms Kemp returned to live in Gagebrook and took up employment at the United Service Station in Bridgewater. She worked there until around 2012.
458. Also in 2007, Ms Kemp met Troy Chamberlain on an internet dating site. Towards the end of that year, Mr Chamberlain moved from Launceston to live with Ms Kemp in her Housing Tasmania residence in Bridgewater.
459. In June 2008, their son, Aiden Kemp, was born.
460. In 2009, a police family violence order was initiated by police and Ms Kemp separated from Mr Chamberlain.
461. Ms Kemp formed a relationship with David Bailey and, in 2014, her youngest child, Christine Bailey, was born.
462. At her time of her death, Ms Kemp lived in Bridgewater with her daughter, Rebecca. She was not in a significant relationship. Two other friends were also staying in the house, being Jason Fahey and Alison Bracken. They had been residing there for five weeks before Ms Kemp's death.
463. At about the age of 14 years, Ms Kemp damaged her coccyx in a fall. At the time, it was noted by doctors that the consequences of the injury may potentially affect future pregnancies. Despite this, Ms Kemp went on to give birth to her five children. However, as a result of the pregnancies, Ms Kemp was diagnosed with disc damage at the level of her L4/L5 vertebrae.
464. Because of the chronic pain associated with her disc damage, Ms Kemp was prescribed Schedule 8 opioid analgesics. Her prolonged use of analgesia (primarily OxyContin and Panadeine Forte), resulted in her being declared prescription drug dependant in 2012 by her regular treating general practitioner. Ms Kemp was also a user of illicit methamphetamine, was a long-term user of cannabis and a cigarette smoker.
465. Additionally, Ms Kemp suffered long-term mental health issues, her diagnoses including personality disorder, anxiety and depression. The evidence indicates that she was unstable in mood and had experienced suicidal thoughts.

### *History of drug use*

466. Prior to 2012, Ms Kemp's regular general practitioner, Dr John Madden, was prescribing Ms Kemp's opioid pain medications. Dr Madden was at Grosvenor Street Medical Practice in Sandy Bay. In April 2012, whilst still under Dr Madden's care, Ms Kemp had entered the Salvation Army's Bridge home-based withdrawal program, attempting to address her opiate dependency.
467. As detailed earlier, Mr Jacometti was the registered nurse involved in the home-based withdrawal program at the time Ms Kemp was participating in it. In that capacity, he had contact with her. Mr Jacometti formed the view that Ms Kemp could benefit from ORT with methadone. He therefore arranged for Ms Kemp to see Dr Jackson. There is no evidence to suggest that Ms Kemp, in her desire to rehabilitate from opiate dependency, expressed any unwillingness to explore ORT or to meet Dr Jackson.
468. Therefore, on 1 May 2012, Ms Kemp met with Dr Jackson for the first time. During this meeting, Dr Jackson noted that Ms Kemp was opiate dependent, smoked cannabis regularly and that when she felt down, she was having suicidal ideations.
469. On 28 June 2012, with a PSB authority, Dr Jackson commenced Ms Kemp on methadone, and immediately prescribed her one takeaway dose per week contrary to the TOPP guidelines.<sup>351</sup> From this date until her death, Ms Kemp was prescribed methadone by Dr Jackson for ORT as well as multiple other psychotropic medications that put Ms Kemp at high risk of overdose and death.
470. For non-ORT medical issues, Ms Kemp still saw Dr Madden who also prescribed her various medications. Dr Madden last saw Ms Kemp on 8 March 2017, four months before her death.<sup>352</sup>
471. From the outset, Dr Jackson's prescribing in almost all respects was so grossly outside safe and proper practice that it is difficult to comprehend such deviation.
472. For example, on 5 July 2012, PSB notified Dr Jackson that Ms Kemp's prescription for the opioid OxyContin should be cancelled and the OxyContin

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<sup>351</sup> CBK15h.

<sup>352</sup> CBK8.

tablets she had received be returned. PSB was apparently so concerned about the risk of Ms Kemp continuing to use OxyContin together with methadone that it asked the relevant pharmacy to utilise police to retrieve the medication from Ms Kemp. However, Dr Jackson contacted PSB the same day and advised that he was happy that Ms Kemp have the prescription, one of the reasons being that she was already purchasing it from other sources (illicitly).

473. On 4 December 2012, Dr Jackson prescribed Ms Kemp two takeaway doses of methadone per week and then, on 20 June 2014, this was increased to three takeaway doses per week. He had additionally commenced prescribing her mirtazapine (a CNS depressant) for depression.
474. A year later, he prescribed her 30mg per day of diazepam which she remained on until her death nearly five years later. This prescribed quantity represents a sixfold increase upon the maximum dosage, being 5mg, recommended for co-prescription with methadone. As a central nervous system depressant and addictive substance, it is universally accepted in the medical profession that benzodiazepines are for short-term prescribing only. It is quite apparent that Dr Jackson, in his medical practice, did not accept nor adhere at all to this standard, let alone the even stricter requirements for prescribing benzodiazepines as set out in the TOPP.<sup>353</sup>
475. Ms Kemp was in regular contact with Mr Jacometti in his role as facilitator of the home-based withdrawal program. This included Mr Jacometti visiting her home, scheduled appointments at the Bridge Centre and through emails and phone calls.
476. A lack of detailed records taken by Dr Jackson about Ms Kemp's care has made it difficult to assess how decisions to increase Ms Kemp's methadone dosage or takeaway doses were made. Dr Jackson did not require Ms Kemp to see him regularly and he often relied on information from Mr Jacometti or from phone calls with Ms Kemp. Mr Jacometti was aware, through his contact with Ms Kemp, that she used methamphetamine illicitly and smoked cannabis regularly.<sup>354</sup>
477. Mr Jacometti's role as an integral conduit for Dr Jackson is seen particularly clearly in the case of Ms Kemp.

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<sup>353</sup> For example, see TOPP 8.6.2 regarding ineligibility for takeaway doses when medium to high doses of benzodiazepines are prescribed.

<sup>354</sup> NB16a.

478. For example, on an occasion in 2017, Ms Kemp wrote to Mr Jacometti as follows:

*“Hi nik, these are the details of the medication. Lyrica, I took the 300mg and I slept all day and night but I think 75 at night to start would be a good place to begin. I have no pain at all and I can feel my left leg for the first time in ages. I am also not as anxious as I have been and I feel a bit happier too which is due to actually having a good nights sleep. Please stress how urgent I need this. I think to stop the clonidine/catapress and start Lyrica asap. Thank you for listening to me and taking me seriously nik. I am so grateful for everything you have done for me over the years I’ve been a client...”<sup>355</sup>*

479. On 12 May 2017, Dr Jackson responded by email to Mr Jacometti, who then passed on the email to Ms Kemp. The email from Dr Jackson simply stated *“Worth trying. So cease clondine and I’ll fax script with for lyrica 75mg nocte. Cheers.”*<sup>356</sup>
480. On 14 June 2017, Dr Jackson prescribed an antibiotic to Ms Kemp for an upper respiratory tract infection. In evidence at inquest, Dr Jackson said that he prescribed Ms Kemp the antibiotic from her history and the fact that she had a productive cough. However, Dr Jackson had no recollection of seeing Ms Kemp or conducting an examination. He could not discount that he did not see her at all but that the prescription had been arranged through Mr Jacometti. Dr Jackson said he did not provide Ms Kemp with any advice regarding the potential adverse respiratory effect of the existing medications as he did not consider they would impair her respiration.<sup>357</sup>
481. Similarly, Mr Jacometti had no recollection of this event. Neither did Dr Jackson’s sparse records indicate whether Ms Kemp was seen personally. It is far more likely that Dr Jackson did not see Ms Kemp personally. In any event, I can confidently make the finding that he did not undertake an adequate history or physical examination.
482. Ms Kemp did not fill the prescription until 22 June 2017.

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355 CBK15d.

356 Ibid.

357 T2832.

### *Circumstances surrounding death*

483. In the days prior to her death, Ms Kemp and those in her household were suffering from what Ms Bracken described as “*the flu*”. Ms Bracken said that Ms Kemp was effectively bedridden. The evidence of those close to her was that she was only leaving her home to attend the Brighton Pharmacy for her supervised methadone dosing.
484. On 4 July 2017, Ms Kemp attended the Brighton Pharmacy where pharmacist Wendy Steinberg noted that Ms Kemp had a “*very chesty cough, shortness of breath, and general malaise*”.<sup>358</sup>
485. Ms Steinberg was so concerned for Ms Kemp that she supplied her with a cough mixture, an inhaler and advised her to see her general practitioner. Ms Kemp expressed that she did not want to go to the doctor. Ms Steinberg said that it was not unusual for Ms Kemp to appear unwell and be prescribed antibiotics for a range of medical issues. She gave evidence that she considered the fact of Ms Kemp not being well but said that there were no contraindications to dosing in the presence of a respiratory infection.<sup>359</sup>
486. At 9.40am on 5 July 2017, Ms Kemp attended the Brighton Pharmacy with Ms Bracken. The pair were driven there by Ms Bracken’s father, Kenneth Bracken.
487. Again, Ms Steinberg was present and noted that Ms Kemp was “*very pale, and off colour. She was unsteady on her feet...She complained of low energy*”.<sup>360</sup> Ms Steinberg asked Ms Kemp to sit down prior to dosing her. Ms Steinberg suggested that an ambulance be called to ensure immediate care but Ms Kemp refused. Ms Steinberg spoke to Ms Bracken and again reiterated the importance of calling an ambulance if Ms Kemp were to lose consciousness.
488. Mr Bracken was also insistent on taking Ms Kemp to the doctor or hospital but again, she refused. She said she would be okay once the antibiotics “kicked in”. Mr Bracken recalled that Ms Kemp appeared very ill, was wearing her dressing gown and slippers, had a cough, and her breathing was heavy.
489. At 10.30am, following the visit to the pharmacy, Mr Bracken dropped Ms Kemp and Ms Bracken at Ms Kemp’s home. Ms Bracken said that Ms Kemp went straight to bed and this was the last time she saw Ms Kemp alive.

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358 CBK21.

359 T1269.

360 CBK21.

490. Later that day, Ms Bracken returned to the pharmacy. Ms Steinberg again followed up with Ms Bracken and gave her the number for the Call the Doctor mobile locum doctor service.<sup>361</sup>
491. At the inquest, Ms Steinberg was questioned thoroughly by counsel assisting about her decision to provide Ms Kemp with a methadone dose, at least before contacting the prescriber, in circumstances where Ms Kemp was exhibiting respiratory compromise. She was also questioned about her knowledge of the TOPP guidelines, which was surprisingly limited. However, Ms Steinberg demonstrated that she was aware of and trained in the previous guidelines.
492. In their closing submissions, counsel assisting accurately summarised the particularly relevant aspects of Ms Steinberg's evidence.
493. I am satisfied that Ms Steinberg was cognisant of the risks of respiratory depression in an unwell person taking multiple CNS depressants. She was also aware of general contraindications to dosing, and assessing the patient's presentation.
494. I find that Ms Steinberg was sufficiently knowledgeable in pharmacotherapy to dose safely. I am satisfied that she turned her mind to the issue of whether Ms Kemp should or should not be dosed in light of her condition. Her decision cannot be criticised.
495. I also agree with her counsel's submission that any finding that Ms Steinberg should have made contact with a medical practitioner, before or after she was dosed, is viewing the matter from an unrealistic hindsight perspective.
496. I find that Ms Steinberg was diligent in her attention to Ms Kemp, was aware that she was very unwell, and attempted on multiple occasions to have her attend the doctor or hospital. Ms Kemp reiterated her advice to Ms Bracken and her father in the presence of Ms Kemp; and again to Ms Bracken separately later in the afternoon of 4 July 2017.
497. Ultimately, Ms Kemp had decision-making capacity and she could not be compelled to seek further medical attention.
498. The next day, 5 July 2017, Rebecca said that she woke up and asked her mother if she could get some food from the shops because there was no food

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361 CBK21.

in the house. In her interview with investigating officers, she said that she heard Ms Kemp say “yes” in a “weird voice” and so she then went to the shops. When she returned home, she said that she went to tell her mother she was back from the shops but when she did not hear anything, left her to sleep.<sup>362</sup>

499. Later that afternoon, Ms Bracken and Mr Fahey returned to Ms Kemp’s home. Shortly after their return, Rebecca told them that she could not wake up her mother and feared she was dead. Ms Bracken entered Ms Kemp’s room and discovered she was deceased. At 5.30pm, Mr Fahey called for an ambulance. Shortly after their arrival at 5.41pm, attending paramedics determined that Ms Kemp was deceased.<sup>363</sup>
500. There is some inconsistency in Rebecca’s interview compared to what she told paramedics at the time. The notes made by attending paramedics specify that Rebecca told them at the scene that she had found her mother at 1.00pm lying supine in bed, stiff and cool to touch. It is further recorded that Rebecca told paramedics that she did not have any phone credit to call for help and so she waited until her mother’s friend returned home at approximately 5.00pm.
501. A search of Ms Kemp’s room by attending police officers found cough syrup, antibiotics and an asthma inhaler, all of which had been used. A range of medications were also within her bedroom and were photographed. These were mirtazapine, Metronide (antibiotic), Lyrica (pregabalin), Eutroxsig (synthetic thyroid hormone), methadone and Antenex (diazepam).
502. I find that Rebecca’s account to the attending paramedics was the correct one. I find that she found her mother deceased several hours before Ms Bracken and Mr Fahey returned home. It would appear that she may have felt guilt about not contacting an ambulance at an earlier stage when it appeared to her that her mother required urgent hospitalisation. In any event, further investigation of Rebecca’s knowledge and actions was unwarranted. She was 14 years of age and cannot be expected to react to such a situation predictably. She did not intend harm to her mother and Ms Kemp was able to call an ambulance herself.

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362 CBK22a at pages 2 and 3.

363 CBK9. Ambulance record.

### *Cause of death*

503. On 7 July 2017, Dr Lawrence performed an autopsy upon Ms Kemp, later producing a comprehensive report containing his findings.<sup>364</sup> Dr Lawrence, for his report, had the benefit of the toxicological analysis of Ms Kemp's postmortem blood and urine samples revealing the presence of many medications and substances.
504. Dr Lawrence determined that Ms Kemp died of aspiration pneumonia caused by combined prescription drug intoxication (methadone, mirtazapine and benzodiazepine). Dr Lawrence explained at inquest that aspiration pneumonia is caused by the inhalation of gastric contents. In this case, aspiration occurred because Ms Kemp's airways were compromised by the effects of the CNS depressants ingested.
505. The toxicology report was authored by forensic scientist Miriam Connor of FSST who undertook the analysis.

In the report, blood results are as follows:<sup>365</sup>

- Alcohol (ethanol) – not detected.
- Carboxyhaemoglobin- 4% saturation: normal range;
- Caffeine – detected;
- Nicotine/Cotinine – detected;
- Methadone – 1.2mg/L: within reported toxic/fatal range;
- EDDP (metabolite of methadone) – detected;
- Mirtazapine – 0.3mg/L: greater than therapeutic;
- Diazepam – approximately 0.17mg/L: therapeutic;
- Nordiazepam (metabolite of diazepam) – detected;
- Oxazepam (a metabolite of diazepam or a single active constituent) – detected;

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<sup>364</sup>CBK5.

<sup>365</sup> CBK6 at page 1.

- Temazepam – (a metabolite of diazepam or a single active constituent) – detected;
- Pregabalin – detected;
- Melatonin – 0.57ug/L: therapeutic;
- Guaiphenesin – 0.62mg/L: therapeutic;
- Ibuprofen – detected;
- Paracetamol – 4.0mg/L: therapeutic;
- THC – (major psychoactive constituent of cannabis) 11ug/L; and
- THC-COOH – (inactive metabolite of THC) - detected.

506. In her report, Ms Connor stated that the Police Report of Death for the Coroner specified that Ms Kemp was prescribed amoxicillin and Eutroxsig. Ms Connor reported that each of those compounds are a “non-target analyte” in the routine screening procedure employed at FSST and therefore neither the presence nor absence of these drugs can be confirmed<sup>366</sup>

507. The initial statement made by Ms Connor in her report regarding the blood results was as follows:

*“Methadone was identified at a concentration that is reported to result in symptoms of toxicity or fatality in some individuals, when used alone. Mirtazapine was identified at a concentration that is reported to result in symptoms of toxicity, in some individuals, when used alone, and may contribute to serotonin toxicity. Multiple central nervous system (CNS) depressants were identified, i.e. methadone, mirtazapine, diazepam, pregabalin and melatonin, which enhances the risk of CNS depression. CNS depression refers to the physiological depression of the CNS that can result in a spectrum of symptoms which may potentially 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).<sup>367</sup>

508. At the commencement of these findings and throughout them, I have explained the properties and effects of methadone and diazepam as CNS depressants. Further, I have emphasised the expert evidence concerning the high risks of taking them in combination. I will not repeat those matters here.

509. Specifically in relation to mirtazapine, Ms Connor reported as follows:

*“Mirtazapine is an atypical antidepressant that is structurally related to mianserin. It is indicated in the in the treatment of depression. Although the mode of action of mirtazapine is not fully known, its antidepressant activity is believed to be related to the enhanced release of noradrenaline and serotonin at nerve junctions. Mirtazapine also has antihistaminergic properties and is, therefore, relatively sedating. Common side effects with mirtazapine use are drowsiness, dizziness, agitation, hypertension and loss of appetite.”<sup>368</sup>*

510. Ms Connor also described pregabalin as a substance that acts to reduce calcium influx and neurotransmitter release producing anticonvulsant, anxiolytic and analgesic effects. Amongst other things, pregabalin is indicated for the treatment of neuropathic pain in adults and for generalised anxiety disorder. Adverse effects of pregabalin include weakness or lack of energy, dizziness and confusion. It is, again, a central nervous system depressant, and therefore also acts to slow breathing and heart rate.<sup>369</sup>

511. The THC blood result was noted by Ms Connor to indicate possible recent use of cannabis by Ms Kemp. She indicated that a proportion of the THC identified may be due to postmortem release from tissues and may not reflect concentration at the time of death. She reported that THC has its greatest effect on the central nervous and cardiovascular systems. It acts to cause cognitive, perceptual and behavioural changes and impairment of sensory functions.<sup>370</sup>

512. A final point of relevance to note from the toxicological results is that the drug guaiphenesin has an expectorant action and is used for the symptomatic relief of chesty coughs. It is generally well tolerated and is available as an over-the-

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367 Ibid.

368 CBK6 at pages with 2-3.

369 Ibid.

370 Ibid at page 4.

counter medication. The presence of this drug in Ms Kemp's system is consistent with her taking cough medicine.

513. Dr Lawrence gave evidence initially on 16 September 2022. He explained his opinion that Ms Kemp died as a result of aspiration pneumonia brought on by a prescription drug overdose. He gave the following evidence:
- a. Ms Kemp's lungs were indicative of pneumonia, and Ms Kemp may have been aspirating before taking the drugs. He said that it typically takes four hours for pneumonia to develop and that the changes in the lungs indicate that it was for longer than a day.
  - b. He did not consider that Ms Kemp's cannabis use would have had a significant effect on the respiratory system and would not be a contributor to drug toxicity. However, cannabis smoking might have contributed to the poor state of her lungs generally.
  - c. Gold fragments in her stomach indicate a reasonable amount of medication was taken orally.
  - d. He accepted that there could be an upper respiratory system infection.
  - e. He theorised that the consistent use of methadone caused respiratory depression over a number of days.
  - f. The cough syrup might increase her sedation.
514. The court also received evidence about Ms Kemp's cause of death from Dr Duflou, who prepared a report dated 4 November 2022.<sup>371</sup>
515. Dr Duflou did not have the benefit of examining Ms Kemp's body. His opinion was entirely based on the documentary material he was provided, as outlined in the letter of instruction.<sup>372</sup>
516. Dr Duflou expressed the opinion that the cause of Ms Kemp's death was pneumonia and possible arrhythmogenic cardiomyopathy, a disease of the heart muscle. Dr Duflou excluded the possibility that drug toxicity played a role, and instead that the medications detected were therapeutic and consistent with long term use.

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371 G37e.

372 C37d.

In particular, Dr Duflou observed:

- a. The reported “*fata*” level of methadone was consistent with a person on methadone maintenance treatment. The levels of benzodiazepines and mirtazapine were in the therapeutic to high therapeutic range, with no level of pregabalin reported. There was no evidence of a sudden increase in the use of those medications.
- b. There was significant other pathology, including:
  - Severe lung disease (combination of aspiration pneumonia, lobar pneumonia and emphysema).
  - Significant but clinically unsuspected heart disease evidenced by enlargement of the heart, abnormal microscopy of the left ventricle myocardium and abnormal right ventricle microscopy.
  - Hypothyroidism.

517. As a result of the provision of Dr Duflou’s report, further opinion was sought from Dr Lawrence.

518. In Dr Lawrence’s further affidavit of 5 May 2023<sup>373</sup> he stated that he believed that Dr Duflou’s suggestion of pneumonia as the cause of death was reasonable. He did not consider cardiomyopathy a cause but it possibly contributed.

519. Dr Lawrence said that there were three possible causes for the pneumonia, being:

- a. Chronic/ recurrent aspiration due to drug toxicity;
- b. Atypical pneumonia (the flu); or
- c. Untreated pneumonia with chronic obstructive pulmonary disease (caused by failure to seek medical attention or to treat with antibiotics).

520. Dr Lawrence still favoured recurrent aspiration due to sedative drugs (noting the toxicology and presence of pill fragments in the stomach) but he did not think this could be “proved” to the requisite standard from the material available.

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373 G38b.

521. Dr Duflou gave evidence at inquest on 23 May 2023.<sup>374</sup> In summary, he said:

- a. Since providing his initial opinion, he had the opportunity to examine the microscopic slides created by Dr Lawrence in the course of the autopsy. He said that the pneumonia he observed appeared to be community-acquired rather than aspiration pneumonia. He estimated that it would have been of at least a few days' duration. He did not see evidence of aspirated material, which he would expect to see for aspiration pneumonia.<sup>375</sup>
- b. He had considered Dr Lawrence's supplementary report. In respect of the aspiration hypothesis, he remained of the view that it was unlikely. He said that there was no indication of it from lung tissue and that the extensive lung damage (across the whole lung) pointed against aspiration.<sup>376</sup>
- c. Dr Duflou agreed with Dr Lawrence that the pneumonia in Ms Kemp presented atypically, but in his opinion, community acquired pneumonia was the most likely cause. He thought that the atypical presentation may have been a result of a viral infection and bacterial infection on top of that (which are pathologically distinct but not clinically so).<sup>377</sup>
- d. He maintained his opinion, even under probing cross examination by counsel assisting, that the methadone and benzodiazepines would not be expected to cause significant respiratory depression.<sup>378</sup> He indicated that there was no evidence that the drugs would have an adverse effect in combination with pneumonia.<sup>379</sup> He speculated that the increased respiratory rate associated with pneumonia may offset any depressant effect.<sup>380</sup>
- e. Dr Duflou said that, in his opinion, Ms Kemp's death from community-acquired pneumonia was because of her failure to seek medical treatment.<sup>381</sup> He could not be specific as to whether, if she had sought treatment in the 48 hours prior to her death, she would have recovered. But he made the general observation that earlier treatment, including

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374 T1915-2020.

375 T1921-T1922.

376 T1925-T1926.

377 T1929-T1930.

378 T1931.

379 T2019.

380 T2026-7.

381 T1933.

oxygen or ventilation as needed, results in a better outcome.<sup>382</sup>

522. Dr Lawrence gave further evidence at inquest on 24 May 2023. In summary, he said:

- a. Pneumonia was clearly the cause of death. In his view, the likely cause was aspiration based on the pill fragments in Ms Kemp's stomach and significant history of opiate use. However, while he said it was the more likely cause of death, he still did not think it could be proved.<sup>383</sup>
- b. His opinion had changed from the original autopsy report since reviewing the histology. He explained this, in part, due to increased familiarity with pneumonia and atypical pneumonia since COVID-19. Upon reviewing the histology, he indicated he could not prove the presence or plant material (from aspirated food) that would establish aspiration pneumonia.<sup>384</sup>
- c. Dr Lawrence ultimately did not distinguish between the likelihood of any of the three possible causes of pneumonia he had identified in his report.<sup>385</sup>
- d. Dr Lawrence gave evidence that he disagreed with Dr Duflou's evidence about the effect of central nervous system depressants on a patient with pneumonia. His opinion was that with extensive pneumonia, a respiratory depressant can make the condition worse. He did not agree with Dr Duflou regarding the respiratory stimulation of an infection counteracting the effects of respiratory depressant substances. Dr Lawrence said, however, that he would defer to the opinion of a clinician on this point.<sup>386</sup>
- e. Dr Lawrence also offered a different view to Dr Duflou about the relevance of the levels of drug toxicity. He opined that the level of drugs were relevant, even though individual tolerance could not be measured reliably. Dr Lawrence's evidence was that it was difficult to determine whether there would have been any effect on Ms Kemp from taking the usual prescribed amount of the central nervous system depressants without knowing her degree of tolerance, noting that methadone had a long life and there was potential for accumulation.<sup>387</sup>

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382 T1934 and 1937.

383 T2060.

384 T2059.

385 T2066.

386 T2061.

387 T2062.

- f. Dr Lawrence gave evidence that Ms Kemp appeared also to have chronic obstructive pulmonary disease (emphysema).
523. Dr Brett, as an appropriately qualified clinician on this issue, was asked to give evidence at inquest. Prior to giving evidence, he was provided with the reports and affidavits of both Dr Duflou and Dr Lawrence.
524. In giving that evidence on 23 September 2023, he said:
- a. It was possible that Ms Kemp had community acquired pneumonia, rather than aspiration pneumonia.
  - b. In his opinion, excessive sedation can make community-acquired pneumonia worse by decreasing respiratory drive and tidal volumes. Ms Kemp had a number of sedatives in her system which had the potential to cause sedation. He opined that if a patient presented with moderate to severe community acquired pneumonia he would be “very anxious” about continuing all the sedatives Ms Kemp was taking and would be ceasing as many as possible.<sup>388</sup>
  - c. Dr Brett indicated that there was “*a very large body of evidence*” which demonstrates that there is a clear relationship between combinations of opioids (including methadone) and high dose benzodiazepines and increase in mortality. The risk of mortality would increase if a person had chronic obstructive pulmonary disease, and such a person would be exposed to higher risks with methadone compared to buprenorphine. He repeated his earlier view that he would make attempts to wean the patient off benzodiazepines in these circumstances.<sup>389</sup>
  - d. Dr Brett also expressed the view that a person would be at increased risk of more severe pneumonia if they had a respiratory infection whilst prescribed methadone and high dose benzodiazepines.<sup>390</sup>
525. Dr Brett was cross-examined. In summary, he gave the following evidence:
- a. That he had not had the benefit of the transcript of evidence at inquest, nor additional forensic evidence since he originally gave evidence.<sup>391</sup>

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388 T2713-5.

389 T2716.

390 T2716.

391 T2721.

- b. He maintained the characterisation of Ms Kemp's benzodiazepine as a high dose. He agreed that the high dose was her "standard" therapy, and that there would be some tolerance. However, he said this fact did not negate all of the risks. He agreed that it was less likely to have a sedative effect if taking it for a long period of time, but that risks such as sleep-disordered breathing and other neuro-hormonal issues to which she would not have developed a tolerance.<sup>392</sup>
- c. He opined that a general practitioner would usually make a diagnosis of COPD and identified a number of symptoms a person might exhibit. If a person had a history of smoking, he would look for chronic lung disease in the patient.<sup>393</sup> In re-examination he explained a number of routine tests a general practitioner might perform when presented with a patient with those symptoms. He said that a prescriber on opioid replacement might not necessarily do those things unless they were particularly thorough. He indicated that prescription of antibiotics by the general practitioner would be the initial treatment for pneumonia and referral for x-rays or the emergency department if it was severe.<sup>394</sup>
- d. His view was that if a person was unwell with a respiratory infection, having multiple sedatives can contributed to a greater deterioration of respiratory function.<sup>395</sup>

#### Conclusion regarding cause of Ms Kemp's death

526. The evidence received from all experts, in thoroughly examining Ms Kemp's cause of death, was of great assistance to the inquest. I make the following findings:

527. I find that Ms Kemp died as a result of pneumonia.

528. I find, accepting the evidence of Dr Duflou and the preponderance of expert evidence, Ms Kemp died as a result of community acquired pneumonia, rather than aspiration pneumonia.

529. I find that Ms Kemp's one week delay in commencing her prescribed antibiotics for her respiratory tract infection may have contributed to the later

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392 T2763-4.

393 T2764-5.

394 T2769.

395 T2768.

development of pneumonia.

530. I find that Ms Kemp's pneumonia was likely a treatable illness.
531. I find that Ms Kemp's refusal to seek medical treatment in the days before her death, despite the urgings of several persons, contributed significantly to her death. She may have recovered with proper treatment.
532. I find that Ms Kemp had developed tolerance to prescribed CNS depressants, including a high daily dose of diazepam.
533. I find that multiple prescribed CNS depressant drugs were in Ms Kemp's system, and several in high quantities.<sup>396</sup>
534. I find, accepting the reasoning of both Dr Lawrence and Dr Brett, that the CNS depressants taken by Ms Kemp increased the risk of her developing pneumonia and, once it had developed, increased the severity of the condition.
535. I find that, whilst arrhythmogenic cardiomyopathy may be a potentially fatal condition, there is no evidence that it had become symptomatic. Therefore, I do not consider that that condition should be articulated as a single secondary cause of death, as Dr Duflou has done in his report. Following that logic, other better secondary causes include Kemp's obesity, dilated cardiomyopathy, emphysema and mixed drug toxicity. All of these conditions were actually present as diagnosed by Dr Lawrence.
536. It is unlikely that the gold pill fragments in Ms Kemp's stomach are significant in her overall toxicology. Their presence remained unexplained at inquest. I note, incidentally, that inexpensive over-the-counter paracetamol by the name "Heron Gold" is apparently widely available from pharmacies and supermarkets and is sold in the form of gold capsules. As paracetamol in apparently reasonably significant quantities was present in Ms Kemp's toxicology results, this may well be an explanation for the presence of the pill fragments.

### *Conclusions regarding Ms Kemp's death*

537. Counsel for Dr Jackson submitted in closing that Dr Jackson's prescribing of methadone and other medications to Kemp was stable over many years and

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<sup>396</sup> I have considered postmortem redistribution in making this finding.

that there is no causal connection between that prescribing and her death.<sup>397</sup>

538. Further, counsel submitted that Ms Kemp's presentation (assuming she did actually present in person) on 14 June 2017 did not require warnings about or reduction of her existing methadone or benzodiazepine use. He also submitted that there was no basis for Dr Jackson to foresee that Ms Kemp would delay in filling the prescription. Similarly, she had access to her other general practitioner and hospital treatment if her condition deteriorated.
539. Accordingly, it was submitted that Dr Jackson did not depart from appropriate care, played no part in the circumstances surrounding Ms Kemp's death and should not be the subject of adverse comment.
540. I agree that any actions, omissions or breaches of standards of care by Dr Jackson did not, in the legal sense, cause or contribute to Ms Kemp's death. A finding that they did is not able to be made, particularly in light of Ms Kemp's apparent stability over preceding months and the fact that death was not due to drug toxicity *per se*.
541. I doubt that Dr Jackson even saw Ms Kemp on 14 June 2017; but if he had, her condition at that stage would probably not have warranted any more than prescription of antibiotics. Although Ms Kemp was deprived of the opportunity of having a thorough assessment and further close monitoring of her condition, such a finding does not make Dr Jackson's sub-standard care part of the causal circumstances of death. This is particularly the case as Ms Kemp's own failure to seek medical treatment as her condition progressed was the main causal circumstance.
542. Again, like the case of Ms Wiki, the evidence regarding cause of death, and factors contributing to it, highlights the benefit of hearing from and testing the opinions of several experts.
543. Despite a cause of death not directly attributable to drug toxicity, I am satisfied in this case that comment about Dr Jackson's treatment and prescribing is sufficiently connected to death to make comments pursuant to section 28 of the Act.
544. Dr Jackson was responsible for Ms Kemp's ORT and prescribing regime over a five-year period. Most of the multiple sedating medications were prescribed

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397 Closing submissions on behalf of Dr Jackson paragraphs 50 – 62.

by him and the presence of these medications exacerbated the illness that caused her death.

545. In his second report, Dr Brett summarised his opinions on Dr Jackson's significant deficiencies in treating Ms Kemp, reporting as follows:

*"I stand by these conclusions and I agree with all conclusions reached in the Coronial Subject Report for BK. On review of the additional evidence provided, I would also like to highlight the following issues:*

*Prescription of take away doses of methadone despite evidence that BK was unstable on opioid substitution program as evidenced below.*

- i. Dr Jackson was aware of BKs mental health concerns including her low mood and suicidality from an early stage when initiating methadone treatment*

*(documented in May 2012 – CKB10). There is evidence of ongoing instabilities in BKs mental state with a police attendance in 12th September 2015 in which BK was agitated and wanting to self-harm. As above with NB, take away doses are concerning in a person at risk of self-harm due to the risk of self-harm with these doses.*

- ii. Ongoing prescription of high dose diazepam (30mg daily). As above, ongoing use of high dose diazepam without a treatment plan or a plan to wean this dose constitutes poor care. It is well known that opioids co-prescribed with benzodiazepines increase the risk of death. This is particularly the case when prescribed with methadone as above due to combined sedative effects. Co-prescription of pregabalin in this context is also concerning. Pregabalin has sedative effects similar to benzodiazepines and is also medication with recognized misuse potential.*
- iii. Ongoing use of methamphetamine and cannabis as observed by N.Azon-Jacometti while BK was attending the Bridge Program.*

*I agree that Dr Jackson's record keeping, clinical communication and clinical review of BK was well below expected professional standards that would be considered safe practice. This is evidenced by the lack of documentation of clinical assessments with BK, the lack of assessments actually performed and lack of communication with BKs GP. I agree with the conclusions of the investigating officer that it is concerning that consultation between BK and Dr*

*Jackson did not occur as the basis of important treatment decisions such as dose changes and increasing take away allowances.*

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*4. It is unclear whether Dr Jackson was aware that BK had chronic lung disease; this may have been apparent had Dr Jackson performed a comprehensive assessment and clinical examination of BK. Chronic lung disease is known to be a predictor of opioid related death in people prescribed methadone. Buprenorphine (suboxone) is usually the preferred OST medication to use in people with advanced chronic lung disease, however, patient preference also factors into the decision on whether to prescribe methadone or buprenorphine. In the presence of advanced chronic lung disease and methadone treatment it is widely recognized as dangerous to co-prescribe other sedatives such as benzodiazepines as they can further compromise respiratory function.”<sup>398</sup>*

546. I fully accept the opinion of Dr Brett as summarised above, which he confirmed in evidence at inquest.

547. If Ms Kemp had been properly managed in accordance with the TOPP and prudent medical practice, there was an opportunity to change the trajectory of her life.

548. This should have involved:

- A plan to wean her off benzodiazepines;
- A gradual reduction of methadone doses;
- Regular consultations to assess her stability and medical conditions;
- Diagnosing and managing her lung disease with care alongside her ORT;
- Switching the ORT to buprenorphine;
- Referral to and encouragement of non-pharmacological avenues of treatment;
- Working with her other general practitioner to ensure safe prescribing and a joint care plan;

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398 G1B (with footnotes and a passage not relevant to this section omitted).

- Keeping careful notes to be able to manage her progress and make sound decisions;
- Not prescribing additional CNS depressants (such as pregabalin prescribed shortly before her death) without first seeing and assessing the indication and risk; and
- Carefully monitoring her condition in the event of an illness that may put her at risk of respiratory compromise.

549. Dr Jackson did none of these things. Ms Kemp did not receive from him basic, safe care. As such, she was deprived of an opportunity to overcome her drug dependence and live a healthy life. She was also deprived of an opportunity close to her death for proper medical monitoring of her respiratory illness with due regard to her high levels of prescription sedatives.

### **Matthew Wayne Winwood**

#### *Background*

550. Matthew Winwood was born on 28 September 1969 in Hobart. He was in receipt of a disability pension and, at the time of his death, was living in a caravan on his mother's property at Rhyndaston.<sup>399</sup>
551. At 10 days of age, he was placed in the care of Kenneth Winwood (Mr K Winwood) and Adriana Juhasz, who at the time were raising seven children aged between 2 and 12 years. He was formally adopted by the Winwood family at 12 months of age.
552. Evidence provided by family members indicates that the adoption had been discussed within the family prior to his arrival, with Ms Juhasz expressing a desire to care for him despite concerns from Mr K Winwood regarding the financial burden of supporting another child.<sup>400</sup> Mr Winwood thereafter grew up as part of the Winwood family household.
553. The family initially resided in Warrane. During Mr Winwood's childhood, the relationship between Mr K Winwood and Ms Juhasz broke down, with Mr K Winwood's longstanding issues with alcohol likely contributing significantly to the separation.

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<sup>399</sup> Rhyndaston is a small rural locality situated 25kms south of Oatlands.  
<sup>400</sup> CMW36.

554. Following the separation, Mr Winwood, then aged approximately 12 years, lived with Ms Juhasz and her new partner, Laszlo (known as “Les”) Juhasz, together with two of his brothers.
555. In 1986, Mr Winwood completed Year 12 at college and subsequently secured an apprenticeship as a spray painter. He later worked in the automotive bodyworks industry for a number of years.
556. Mr Winwood had several relationships throughout his life but never married. His longest relationship was with Dale O’Brien between 2001 and 2013. He fathered one son, Christian, born in 1994 to Christine Kannegiesser. Evidence indicates that Mr Winwood became estranged from his son during the child’s infancy.
557. At some stage after the breakdown of a relationship, in the mid-1990s, Mr Winwood relocated to Darwin for work. During this period, family members lost contact with him for some time. It was later reported that he had undertaken work as a pearl diver and tour guide. A family acquaintance subsequently informed relatives that Mr Winwood had been encountered in Darwin in poor condition following drug use. Family members pooled funds to facilitate his return to Tasmania.
558. Following his return, it became apparent to his family that Mr Winwood had developed a significant dependence on prescription medication. However, Mr Winwood attributed the commencement of his use of pain medication to a workplace or accidental injury involving the loss of part of two fingers, stating that he had become dependent upon pain medication following treatment in hospital.<sup>401</sup>
559. Ms O’Brien, in her comprehensive statutory declaration for the investigation, described Mr Winwood’s health and drug and alcohol use from 2001 onwards.<sup>402</sup>
560. In April 2002, a drug and alcohol binge left Mr Winwood comatose for several days. He suffered bilateral compartment syndrome and was hospitalised for a lengthy period of time. He was left with permanent disfigurement of his legs.<sup>403</sup> Ms O’Brien said that after his hospitalisation, he used “whatever he could get

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401 CMW30 and CMW40.

402 Mr Winwood had returned from Darwin by that time: CMW40.

403 CMW13.

his hands on.”<sup>404</sup>

561. Evidence from family members described Mr Winwood regularly attending medical appointments with handwritten lists of prescription medications he intended to request. On occasions, these lists were prepared prior to leaving home, while at other times they were written in the car before appointments. When they questioned him about the lists, Mr Winwood would say that they assisted him in remembering which medications to request and expressed confidence that doctors would prescribe the medications sought.<sup>405</sup>
562. In 2006 or 2007, Mr Winwood relocated to Launceston after Ms O’Brien had been living there for approximately 12 months. During this period, he obtained employment with a bodyworks business in Launceston.<sup>406</sup> Ms O’Brien observed that his overall functioning and substance use improved while he remained employed.<sup>407</sup>
563. Over subsequent years, however, Mr Winwood’s physical health deteriorated and his addiction to drugs escalated. Evidence indicates that he consumed alcohol regularly and often in substantial quantities in addition to misusing prescription medications. He displayed increasing episodes of anger, irrational behaviour and aggression associated with intoxication. Police attendance at the home was required on multiple occasions due to his threatening behaviour. It appears that he was injecting drugs intravenously in the early years of his relationship with Ms O’Brien but attempted to conceal it from her.<sup>408</sup>
564. Mr Winwood first came to police attention in 1987 when he was charged with trespass, stealing, and three counts of preparing and administering a narcotic substance. In 1988, he was charged with burglary and stealing following a break-in at a pharmacy during which benzodiazepines and cash were stolen.<sup>409</sup>
565. In 2005, Mr Winwood was convicted on two separate occasions of driving under the influence of alcohol and driving under the influence of drugs. During one of those incidents, he informed police he had injected MS Contin (morphine) 30mg and consumed 30 Valium tablets.

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404 CMW40 page 3.

405 CMW34.

406 CMW40.

407 CMW40.

408 CMW40 page 3.

409 CMW62.

566. Between January 2009 and March 2013, Mr Winwood had no recorded interactions with Tasmania Police. However, on 2 August 2013, police attended the family property at Rhyndaston after reports that Mr Winwood, whilst intoxicated, had been smashing walls within the residence. He informed police he had consumed two bottles of spirits and returned a blood alcohol reading of 0.250g/100mL.
567. In 2015, Mr Winwood was charged on three occasions with driving whilst under the influence of alcohol, recording blood alcohol concentrations exceeding 0.05g/100mL on each occasion. In May 2016, he was arrested in relation to outstanding warrants, driving whilst disqualified, and other driving offences.
568. From 14 February 2017 until the time of his death in August 2017, Mr Winwood was required to report twice weekly by signing a bail book at Oatlands Police Station.
569. Sergeant Robert Cooke,<sup>410</sup> stationed at Oatlands, had dealings with Mr Winwood on approximately ten occasions during that period and recalled him attending the station in varying states of sobriety, often displaying signs consistent with alcohol and/or drug intoxication.
570. Sergeant Cooke stated that he regularly questioned Mr Winwood regarding his welfare and level of intoxication, to which Mr Winwood would commonly respond that he had recently consumed bourbon or taken prescribed medication prior to attending the station.<sup>411</sup>
571. On 7 May 2017, police officers were called by Ms Juhasz due to Mr Winwood being highly intoxicated, aggressive and verbally abusive.

### *History of drug use*

572. Mr Winwood's issues with drug and alcohol abuse commenced in the mid-1990s when he moved to the Northern Territory. Royal Darwin Hospital records reveal that Mr Winwood presented to the emergency department on multiple occasions exhibiting drug seeking behaviour.
573. In 2000, Mr Winwood's family members became aware that he was abusing drugs in Darwin and arranged for him to return to Tasmania. Mr Winwood told

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410 Now deceased.

411 CMW51.

Ms Juhasz that he became addicted to opioids and benzodiazepines after having his fingers amputated in Darwin. This is not supported by medical notes from the Royal Darwin Hospital which indicate that Mr Winwood's fingers were amputated after they became gangrenous from injecting drugs into them.<sup>412</sup>

574. After moving back to Tasmania in 2000, Mr Winwood was under the care of Dr George Whyte of Eastern Shore Medical Centre. Dr Whyte cared for Mr Winwood until 2005. During this time Dr Whyte was aware of Mr Winwood's issues with alcohol and drugs and arranged for him to attend ADS for counselling and support in October 2000. The goal was taper him off medication. Whilst Mr Winwood attended ADS on a number of occasions in 2001 and 2002, the treatment was unsuccessful.
575. As detailed above, in April 2002, Mr Winwood was diagnosed with bilateral compartment syndrome after a drug and alcohol binge left him with disfigurement of his legs and chronic pain. His mother, in her affidavit, said that the damage occurred when he fell asleep in a position that restricted the blood flow to his legs.
576. At various times between January 2001 and August 2005, Mr Winwood was reported to be "doctor shopping" for medication. PSB was notified and issued circulars to pharmacies. During this time Mr Winwood was also reported to have stolen blank prescriptions, sold drugs, shared his medication and fraudulently acquired two Medicare cards in different names.
577. Dr Whyte referred Mr Winwood to Dr Hilton Francis, a pain specialist at the RHH Outpatients Pain Clinic and Dr Francis further referred Mr Winwood on to Dr Jacob George, a substance abuse specialist at the RHH. PSB gave authority for Dr Francis, Dr George and Dr Whyte to prescribe 10mg Physeptone (methadone hydrochloride) to Mr Winwood between April 2003 and August 2005.
578. In August 2005, PSB and ADS expressed concern about Mr Winwood's care and potential risk of overdosing. They agreed that Mr Winwood should only be dosed under supervision and with no takeaway doses. Mr Winwood was unhappy with this and called ADS and abused staff.
579. It was recommended at the time by PSB that ADS review Mr Winwood's care. Dr Jackson was the current Clinical Director of ADS. On 7 September 2005 he

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412 CMW10.

met with Mr Winwood and conducted a detailed review. Dr Jackson took over Mr Winwood's care for the next three months.

580. Dr Jackson prescribed Mr Winwood 10mg Physeptone, up to a maximum of 90 tablets a month for a three-month period. Dr Jackson felt this was safe as Mr Winwood 'does not inject it'. This was despite, in June 2005, Mr Winwood injecting MS Contin he had purchased illegally. Dr Jackson also recommended that Mr Winwood be allowed three takeaway doses per week, although there were indicators that he was not stable.
581. Between October 2005 and 2013 Mr Winwood moved to Launceston and became a client of ADS North where he was treated by Dr Gerard Gill until 2011 and Dr Mahendran Gajaharan until 2013.
582. Dr Gill described Mr Winwood as "troublesome" when takeaway doses were removed because benzodiazepines were detected in his system. Dr Gill said that Mr Winwood was particularly difficult in agitating against removal of his takeaway doses through the channel of his partner's father, who was a federal politician.<sup>413</sup>
583. Despite achieving relative stability for several years, Mr Winwood was transferred onto methadone syrup and began to return random urine drugs tests identifying benzodiazepines and amphetamines. His alcohol intake had also increased significantly.
584. Between November 2011 and September 2013, Mr Winwood returned 35 positive random urine tests for benzodiazepines and on occasions, amphetamines. Mr Winwood's stepfather, Laszlo Juhasz, died in November 2011 and his passing may have contributed to a decline in Mr Winwood's mental wellbeing.
585. In August 2013, Mr Winwood raised the idea of transferring to the ADS South Inpatient Withdrawal Unit to address his binge drinking behaviour. At the time, he was living between his mother's house in Rhyndaston and his sister's house, and both were struggling to cope with his behaviour.
586. At about this time Tasmania Police were also advised that Mr Winwood was living in his car and driving frequently under the influence of drugs or alcohol.

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413 CMW45 Statutory Declaration of Gerard Gill.

587. Concerned with Mr Winwood's instability and risk of overdose, ADS North started reducing Mr Winwood's methadone doses. The aim was to transfer him onto suboxone, a form of buprenorphine which is safer than methadone and does not require daily dosing. At the time, Mr Winwood was missing appointments, returning positive urine drugs tests, his takeaways had been stopped and the need for an inpatient admission had become critical.
588. Mr Winwood had become disgruntled with ADS North and he was discharged from its care in October 2013. His prescription at that time from Dr Gajaharan was 25mg methadone with no takeaway doses.
589. In or around September 2013, Mr Winwood met Mr Jacometti at the Salvation Army, who introduced him to Dr Jackson. Subsequently ADS North was informed that Dr Jackson would be taking over his care and Mr Winwood was discharged.
590. Dr Gajaharan advised Dr Jackson of Mr Winwood's ongoing instability, concerns for his safety and the need to transition him to suboxone which requires a reduction in methadone.<sup>414</sup>
591. Instead, Dr Jackson increased Mr Winwood's methadone dose from 25mg to 35mg. It is at this critical point that Dr Jackson's care departed from the plan of ADS North and the requirements of the TOPP guidelines. ADS North planned, correctly, to transition Mr Winwood to Suboxone, a much safer option in terms of misuse and does not require daily dosing. It appears that the plan was achievable.
592. In November 2013, Dr Jackson further increased Mr Winwood's to 45mg.
593. By December 2013, Mr Winwood was prescribed 55mg per day of methadone with two takeaway doses per week. This was despite Mr Winwood continuing to display clinically unstable behaviours.
594. By February 2014, Dr Jackson had increased Mr Winwood's methadone dosing to 60mg per day with three takeaway doses per week.
595. On 24 February 2014, Dr Jackson also applied for authority from PSB to prescribe Mr Winwood Physeptone tablets to treat his pain. In the application, Dr Jackson stated that Mr Winwood was "*not drug dependant...and his past*

*drugs problems have been situational and included alcohol and benzodiazepines, both of which he is free of at the moment*".<sup>415</sup> This assertion about Mr Winwood's stability was utterly inconsistent with a statement from a reasonably diligent addiction specialist complying with recognised standards.

596. PSB invited Dr Gajaharan from ADS North to comment on Mr Winwood's relative stability. PSB recorded that Dr Gajaharan advised that Mr Winwood has not shown long term signs of stability, and was concerned about his use of benzodiazepines and alcohol.
597. PSB further consulted with Dr Adrian Reynolds and the decision was made to refuse Dr Jackson's application. In its decision, PSB referred to Mr Winwood's bingeing of diazepines, alcohol abuse, history of intravenous substance abuse. PSB also noted the lack of independent evidence to support Mr Winwood being free of alcohol and benzodiazepines, and lack of evidence supporting the use of benzodiazepines for pain management.
598. In March 2014, Mr Winwood had foot surgery and was experiencing pain as a result. Dr Jackson prescribed 20 x 5mg Endone<sup>416</sup> tablets. PSB was advised of this as Dr Jackson was not authorised under the *Poisons Act* to do so. Mr Winwood was prescribed Endone by Dr Jackson for 47 days, during which time he was also receiving between five and seven takeaway doses of methadone a week.
599. By the end of May 2014, Mr Winwood was prescribed 70mg methadone per day with three takeaway doses per week. Dr Jackson also regularly authorised additional takeaway doses, citing Mr Winwood's limitation of movement as the justification.
600. Mr Winwood was incarcerated between 6 and 14 July 2014. Upon being released, Dr Jackson immediately prescribed Mr Winwood five takeaway doses. There is no explanation for why Dr Jackson made this irresponsible decision, being a breach of the TOPP in at least three respects.
601. For the month of September 2014, Mr Winwood's methadone dose was decreased from 70mg to 60mg, still with three takeaway doses prescribed. It was further decreased to 55mg with additional takeaway doses prescribed. There are no supporting patient notes from Dr Jackson to explain this decision

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415 CMW12.

416 Endone is a brand name for the opioid oxycodone.

- to decrease his methadone dose.
602. On 4 November 2014, a prescription for 120 Physeptone tablets in the name of Adriana Juhasz was filled. Enquiries were made by PSB, and it became apparent that the prescription was filled by Mr Winwood.
603. On 16 March 2015, PSB received a call from Dr Clive Stack. He informed PSB that a patient of his was aware that a patient [Mr Winwood], receives up to six takeaway doses per week, is prescribed oxazepam which he “uses in one go” and uses alcohol in an unsafe manner.<sup>417</sup>
604. Between May 2015 and April 2016, Mr Winwood presented to the RHH emergency department on three occasions, having overdosed. The substances involved included methadone, alcohol, oxazepam, olanzapine, diazepam and panadeine.
605. In September 2015, Mr Winwood presented to the Oatlands Medical Centre after overdosing on oxazepam, olanzapine, methadone and alcohol.
606. Dr Jackson continued to prescribe Mr Winwood takeaways doses of methadone.
607. Dr Jackson saw Mr Winwood once in August 2016 and not at all in September or October 2016.
608. On 24 October 2016, Mr Winwood was taken into custody for breach of bail. He had 25 diazepam tablets and one bottle of methadone in his possession at the time.
609. Mr Winwood was released from prison on 16 November 2016. Dr Jackson saw him the day after his release, and no changes were made to his methadone dosage or takeaway doses.
610. In June of 2017, Mr Winwood was attended to by ambulance paramedics after collecting his daily methadone dose from North Hobart Pharmacy. I will discuss this event in more detail shortly.
611. At his time of death, Dr Jackson was prescribing Mr Winwood 70mg of methadone per day plus five takeaway doses per week. It appears that Mr Winwood’s rural location, his driving disqualification and his physical

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417 CMW12.

disabilities were taken into account by Dr Jackson in prescribing this inordinately high number of takeaway doses.

612. In fact, he received an average of six takeaway doses per week in 2017. Additionally, Dr Jackson prescribed Mr Winwood oxazepam and temazepam (benzodiazepines in high amounts), pregabalin and olanzapine.
613. There is also evidence to suggest Mr Winwood was doctor shopping again in the months leading up to his death, as an additional prescription for benzodiazepines was obtained from Dr Michael Lees, a general practitioner in Oatlands.

### *Circumstances surrounding death*

614. On 31 July 2017, Mr Winwood was taken to see Dr Jackson by Lorraine Coulson, a close family friend. Ms Coulson swore a detailed affidavit for the investigation and gave very credible and helpful evidence.
615. In her affidavit, she described the extent of Mr Winwood's drug and alcohol addiction. She said that she would drive Mr Winwood to see Dr Jackson once per fortnight
616. Ms Coulson commented that many of the appointments seemed very quick. She said that Mr Winwood would tell her with a grin that Dr Jackson "will give me what I want."<sup>418</sup> Mr Winwood would also say the same to his mother, who expressed anger and dismay about the quantity of drugs being provided to her son by Dr Jackson. She said that she tried to contact Dr Jackson to stop him prescribing but was unsuccessful. Ms Juhasz was of the view that Mr Winwood not have sourced drugs illicitly if prescribing was curtailed.
617. In her affidavit, Ms Coulson described taking Mr Winwood to see Dr Jackson on 31 July 2017. She said:

*"On the Monday before Matthews's death I took Matthew to see Dr Jackson at Rokeby at about 1.00pm. Matthew had been drinking again. He was affected by alcohol before we left home. On the way down he was again drinking bourbon in the car, mixing his own drinks along the way. Matthew also wrote out a list of prescription medications that he wanted to get. I saw that Matthew had written out five lots of tablets on*

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<sup>418</sup> CMW34.

*the list. When we arrived at Rokeby I would say Matthew was about three quarters drunk, you could smell the alcohol on him and he was in a poor state in relation to his personal hygiene, I know he hadn't bathed for over a week. Matthew went into the surgery and was only in there for 5-6 minutes maximum. Matthew came out of the surgery with I think 4-5 prescriptions. We drove to the Shoreline shopping centre, I went to the supermarket and Matthew went to the Chemist and the bottle shop. When I came back to the car, Matthew was already there, he had filled his scripts and bought two bottles of Woodstock bourbon.*<sup>419</sup>

618. No one at the Rhyndaston property saw Mr Winwood on 1 of August 2017, although this was not unusual. Mr Winwood would spend long periods of time in his caravan. However, that day he did attend Oatlands Pharmacy, where pharmacist Stephen Ives administered a methadone dose to him as well as giving him three prescribed takeaway doses. Mr Ives gave evidence at inquest but did not make a statement earlier in the investigation.
619. Mr Ives could not recall Mr Winwood's attendance. Like the other pharmacists, saying he was well-versed in the TOPP guidelines. He gave sound evidence about his usual practice with ORT patients, and the signs that may be a contraindication to dosing, including physiological changes and drug or alcohol toxicity.<sup>420</sup> I am satisfied that he followed that usual practice by assessing Mr Winwood before and after dosing, and that Mr Winwood did not display any signs of intoxication or give Mr Ives any reason to be concerned.
620. Mr Ives did say in evidence that, in his experience, prescribers mostly followed the TOPP guidelines, but with "wriggle room" regarding takeaway doses, and he commonly saw general practitioners prescribing three consecutive doses.<sup>421</sup> However, Mr Ives dispensed as prescribed, with reasonable care. Criticism of his dispensing is not justified.
621. The following day, 2 August 2017, Mr Winwood was observed moving around his caravan. Later that day, he came into the house around dinner time and spoke with Ms Juhasz and Ms Coulson. Both noted that Mr Winwood appeared very dishevelled and his personal hygiene appeared poor.<sup>422</sup> Ms Juhasz said in her affidavits that her son was somewhat "under the weather on

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419 CMW34.

420 T1247.

421 T1250.

422 CMW34.

*drugs*" but seemed quiet and was walking around in a dream.<sup>423</sup> He retired to his caravan and was not seen again that night.

622. On the morning of 3 August 2017, Ms Coulson, Ms Juhasz and her son Leon left home to go into town. As they left, they observed Mr Winwood at the window of his caravan waving to them.<sup>424</sup>
623. Mr Winwood was not seen alive after this time.
624. At 9.30am on 4 August 2017, Ms Coulson saw Mr Winwood's leg hanging out the door of his caravan. Ms Coulson and Ms Juhasz went to have a closer look and found Mr Winwood cold and unresponsive. Ms Juhasz went back into the house, retrieved a towel and asked Ms Coulson to cover Mr Winwood's leg.<sup>425</sup> They called for an ambulance. Attending paramedics determined that Mr Winwood was deceased. Police officers also attended the scene and commenced the investigation into Mr Winwood's death.
625. The attending police officers saw Mr Winwood slumped in the doorway of the caravan with his left leg protruding from the door. There was a large amount of blood throughout the interior of the caravan and vomit in the door area. Police officers from Forensic Services and CIB subsequently attended. Bloody footprints were located at the front of the caravan and a significant laceration was observed on Mr Winwood's right foot.
626. It was thought by the attending officers that the laceration was caused by an accident, most likely by Mr Winwood stepping on jagged metal around the caravan. It appeared to them blood from the laceration was the source of the blood in the interior of the caravan. The attending officers formed the view that there were no suspicious circumstances or evidence of any other person being involved in Mr Winwood's death. I am satisfied that is the case.
627. As part of their search, the officers located and seized multiple bottles of whiskey in varying states of consumption, one empty and one full bottle of 70mg methadone syrup dispensed by Oatlands Pharmacy, four empty bottles of oxazepam dispensed by Dr Jackson, four empty bottles of methadone dispensed by Jerry Hampton Pharmacy Hobart, twelve empty foils of 75mg Lyrica and eleven empty foils of Chemmart olanzapine 10mg.

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423 CMW29.

424 CMW29 and CMW33.

425 An unusual response but not suspicious.

628. Consistently with the medication and packages found at the scene, Dr Jackson's prescribing to Mr Winwood in the period before his death was as follows:

- On 21 July 2017, Dr Jackson prescribed oxazepam 30mg x 100 x 2 repeats.
- On 31 July 2017, Dr Jackson prescribed pregabalin 75mg x 56 x 5 repeats; temazepam 10mg x 25; and olanzapine 10mg x 28 x 5 repeats.
- On 1 August 2017, to Dr Jackson prescribed one supervised methadone dose and three takeaway doses (70mg).

### *Cause of death*

629. Mr Winwood's cause of death was the subject of considerable evidence and in particular, from Dr Ritchey and Dr Duflou. Importantly, there was a difference in opinion between them concerning whether drug intoxication was a cause, or a significant cause, of Mr Winwood's death.

630. Dr Donald Ritchey performed an autopsy on 7 August 2017 upon Mr Winwood and produced a report.<sup>426</sup> As with the autopsies conducted in respect of the other three deceased, the forensic pathologist from the Office of the State Forensic Pathologist in Tasmania performs his or her functions for the purpose of the coronial investigation in accordance with the provisions of the Coroners Act 1995.<sup>427</sup>

631. Dr Duflou, on the other hand, was retained by the pharmacists in November 2022, prior to the commencement of the inquest. He gave his opinion on the basis of evidence provided to him in accordance with a letter of instruction and selected evidentiary exhibits.<sup>428</sup>

632. At the outset, it should be noted that both Dr Ritchey and Dr Duflou are highly qualified in their medical specialty and have considerable experience in conducting autopsies and determining causes of death, including persons who have died as a result of drug overdose in a variety of circumstances. There was no submission from any counsel that the expertise of one of the forensic pathologists was superior to that of the other.

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426 CMW6 and CMW6a.

427 Sections 17, 18, 35 and 36.

428 G37h.

633. In forming his view, Dr Ritchey had regard to not only his external and internal examination of Mr Winwood, but the results of samples from histological examination, toxicological analysis of Mr Winwood's blood, urine and vitreous fluid; together with the police report of death and digital scene photographs.

634. From these investigations, Dr Ritchey made specific findings in his report under the heading "*pathological diagnosis*". In summary, these findings were:

- (a) Mixed prescription drug toxicity (with methadone, olanzapine, pregabalin and benzodiazepine metabolites);
- (b) Intravenous drug use, shown by foreign body giant cells containing refractile crystalline debris in the lungs;
- (c) Chronic hepatitis with portal fibrosis grade 3, stage 2;
- (d) Incised injury, being a 5cm cut on the medial aspect of the right foot with no subcutaneous haematoma and no grossly evident large vessels incised;
- (e) Atherosclerotic and probable hypertensive cardiovascular disease, evidenced by cardiomegaly, concentric left ventricular hypertrophy, multi-focal stenotic atherosclerosis of the left anterior descending coronary artery with approximately 60% stenosis, aortic atherosclerosis, arteriolonephrosclerosis with cortical infarct; and
- (f) Emphysema and active respiratory bronchiolitis.

635. Specifically, toxicological analysis of Mr Winwood's postmortem blood samples indicated:<sup>429</sup>

- Methadone within a toxic/fatal range;
- Oxazepam at a reported therapeutic level;
- Temazepam at a reported therapeutic level;
- Pregabalin (Lyrica) detected;
- Olanzapine detected; and
- No Alcohol was detected.

636. On the basis of his findings, Dr Ritchey formed the view that the primary cause

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429 CMW7.

of death was mixed prescribed drug toxicity, particularly noting that all drugs identified are strong nervous system depressants that can cause death by respiratory depression. He gave significant contributory factors as emphysema, active respiratory bronchiolitis, atherosclerotic and hypertensive cardiovascular disease and chronic hepatitis.

637. Dr Ritchey gave oral evidence at inquest on 12 September 2022 and commented upon his conclusions in his report. Relevantly, he testified that:
- a. The combination of methadone and benzodiazepines was a particularly problematic combination in terms of central nervous system depression, increasing the risk of death by asphyxiation.<sup>430</sup> He said that the specified postmortem concentration of methadone may be unreliable.<sup>431</sup>
  - b. The heart disease may have been present without any symptoms, and therefore unlikely to have been diagnosed by a medical practitioner.<sup>432</sup>
  - c. The fact that Mr Winwood had no alcohol in his system could theoretically have led to alcohol withdrawal symptoms. However, he was very firm in his view that an alcohol withdrawal seizure was not the cause of death.<sup>433</sup>
638. Dr Duflou, in his report, opined that the primary cause of Mr Winwood's death was positional asphyxia, given his position wedged in the footwell of his caravan. Therefore, he died because he was in a hunched or cramped position that prevented him from breathing.
639. Dr Duflou said that some other conditions potentially contributed to death - including alcohol withdrawal, foot injury, limb weakness, heart and lung disease and effects of medications.<sup>434</sup>
640. Dr Duflou gave evidence on 23 May 2023, where he explained the basis of his opinion as to cause to death. He placed particular reliance upon the scene photographs depicting Mr Winwood in the position in which he was discovered deceased, as well as evidence of lividity on his stomach.<sup>435</sup>

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430 T91.  
431 T105.  
432 T99-T100.  
433 T108.  
434 G37i.  
435 T1965.

641. He emphasised in his evidence at inquest that positional asphyxia could be properly regarded as a primary cause of death, and not just the mechanism of death, although he acknowledged that there was inevitably a further cause for the person being in that position).<sup>436</sup>
642. Dr Duflou's evidence was that all, or any, or any combination of the underlying causes of death previously referred to, could have given rise to the position of Mr Winwood which resulted in positional asphyxia.<sup>437</sup>
643. Dr Duflou's opinion was that a seizure from alcohol withdrawal could not be excluded as a contributory factor in death. He noted that in June 2017, some two months prior, Mr Winwood appears to have had a seizure as a result of alcohol withdrawal.<sup>438</sup> He referred to academic articles which he indicated supported a proposition that tolerance to benzodiazepines could reduce their effectiveness in controlling seizures.<sup>439</sup> He stated that benzodiazepines were the best treatment for alcohol withdrawal seizures but that patients may have break through seizures, or the drugs may be ineffective.
644. Dr Duflou's view was that cause of death could not be attributed to drug toxicity in any significant way. In evidence he said "*...in this case there's simply too much else going on to attribute it to drug toxicity. I have no issue with potentially the effects of the various substances that he's on adding to the effect of him being in the position he's in, but I don't think he has died of effectively a drug overdose.*"<sup>440</sup>
645. In Dr Duflou's opinion, evidence of Mr Winwood moving about the caravan was inconsistent with drug toxicity.<sup>441</sup>
646. In respect of the other possible contributing cause, Dr Duflou said that Mr Winwood's foot injury may have caused hypovolemic shock due to blood loss.<sup>442</sup>
647. He also said that his heart and lung disease may have contributed but it was not a primary initiating event.<sup>443</sup>

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436 T1966.

437 T1975.

438 T1966-7.

439 T1969-73.

440 T1979 (verbal fillers removed from quote).

441 T1979-80.

442 T1980.

443 T1980.

648. Dr Ritchey provided a further report of 5 April 2023 in response to Dr Duflou's report.<sup>444</sup> He gave evidence at inquest for the second time on 24 May 2023, his evidence being consistent with both his first and second reports and did not change his view upon cause of death.

649. Specifically, in evidence, Dr Ritchey stated the following:

- a. He was not persuaded to change his opinion having regard to Dr Duflou's report.<sup>445</sup>
- b. He maintained that he considered alcohol withdrawal a theoretical but unlikely possibility in Mr Winwood's death. This was the case even though, in his original report, he was unaware of Mr Winwood's possible episode in June 2017 possibly caused by alcohol withdrawal.<sup>446</sup>
- c. He maintained his view that the presence of benzodiazepines in a therapeutic level would have been likely to prevent significant seizure activity but accepted that tolerance may have reduced the effect.<sup>447</sup>

He dismissed hypovolemic shock causing unconsciousness from the foot injury as a cause of death. He gave evidence that the blood loss could not be quantified.<sup>448</sup>

- d. He favoured the view that positional asphyxia was the mechanism, rather than real or underlying cause of death. He maintained his view that the underlying cause was mixed drug toxicity.<sup>449</sup>
- e. The photograph of the deceased did not reveal that positional asphyxia had *definitely occurred*.<sup>450</sup>
- f. His view was that the spread of blood around the caravan was evidence of a delirious state as no steps had been taken to stem the flow, and consistent with being affected by mixed drug toxicity which was supported by the number of different substances in Mr Winwood's system.<sup>451</sup>

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444 G38d.

445 T2094.

446 T2121-2.

447 T2095.

448 T2099.

449 T2100.

450 T2101.

451 T2125-6.

650. In summary, Dr Duflou's opinion was that positional asphyxia caused Mr Winwood's death; with the possibility of one or more of the other conditions contributing to his final hunched position where his airways were compromised.
651. Dr Ritchey was open to considering that positional asphyxia might be a reasonable mechanism of death, but said that this begs the question of why Mr Winwood came to be in a position where his respiration was fatally compromised. It is apparent that Dr Ritchey's investigations focused from the beginning upon the operative, underlying cause of death.
652. Under section 28(1)(c) of the Act I am required to find, if possible, the cause of death of a deceased person.
653. Whether positional asphyxia is classified as a mechanism or cause, it does not, of itself, fulfill the requirement of the section in this case to find the real or operative cause of death. I did not take any counsel to dispute the necessity to inquire into and determine the significant cause or causes of Mr Winwood's death.
654. This case is complex, as recognised by the expert witnesses. The duty of the coroner is to find, if possible, the cause of death to the requisite legal standard having regard to all of the evidence available at the inquest. It does not involve speculation or guesswork. Often in coronial cases, several possibilities are potentially available to explain a death. The coroner's duty is to identify, upon the available evidence, the most likely cause in the circumstances in accordance with all of the evidence.
655. The issue of alcohol withdrawal as a possible cause was thoroughly explored at inquest. Consideration of the factual context of Mr Winwood's alcohol and drug consumption is very important.
656. The inquest heard evidence from his sister, Debby Richardson. She was an impressive and articulate witness, and close to Mr Winwood. She also provided a comprehensive statutory declaration.<sup>452</sup> Ms Richardson said that, in the last 12 months of his life, Mr Winwood would be "*high*" following receiving his prescription medication from Dr Jackson and would not drink alcohol on these occasions. She explained in evidence:

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452 CMW37.

*“Well when he used to go to the doctors (sic) and get his scripts he was high for a few days. Like I’m sure he used the lot and then he wouldn’t have any so he’d drink for a few days and then he’d be sober for a few days...”*<sup>453</sup>

657. I find upon the evidence that Mr Winwood, having collected his multiple prescriptions from Dr Jackson on 31 July 2017, commenced to take excessive quantities in accordance with his usual practice. I find that when he returned home with the medication that day, he ceased alcohol consumption, also in accordance with his usual practice.
658. I find that the toxicology results showing multiple of his prescribed substances in dangerous combination, but no alcohol, is completely consistent with Mr Winwood “bingeing” on the drugs supplied by Dr Jackson.
659. On the other hand, there is no positive evidence at all that Mr Winwood had an alcohol withdrawal seizure that caused or significantly contributed to his death. The proposition seems speculative, particularly in the face of actual evidence of his collection of a large quantity of drugs, his known practice of consuming them excessively and the toxicology results. However, the issue requires discussion.
660. On 21 June 2017, Mr Winwood suffered what appeared to be a seizure. The seizure occurred in North Hobart following Mr Winwood receiving a pharmacy dose of methadone, three takeaway doses and 12 x 30mg oxazepam tablets. The report from attending paramedics stated that he was seen “*to take a swig of methadone*” from a takeaway bottle following his dosing and just before the seizure.<sup>454</sup> It is unclear what other substances he had.<sup>455</sup> Doctors at the RHH, where he was transported by ambulance, thought that a possible diagnosis was alcohol withdrawal.<sup>456</sup>
661. Further, his long history of emergency presentations to hospitals have involved both drug and alcohol intoxication. There is no logical reason to find in these circumstances that the June presentation was, in fact, related to a symptom of alcohol withdrawal rather than effects of drug intoxication.

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453 T1600 (verbal fillers removed).

454 CMW11b page 8.

455 The hospital records indicate he may have only had one full methadone bottle in his possession, out of the three takeaway doses.

456 CMW11b.

662. I find, upon the evidence, that benzodiazepines are generally the most effective prevention for alcohol withdrawal seizures. I accept that tolerance may weigh against the benefits in Mr Winwood's case but his ingestion of quantities of two separate benzodiazepines militates against a seizure causing death.<sup>457</sup>
663. I am satisfied that alcohol withdrawal, or its effects, is not causative or contributory to Mr Winwood's death.
664. Similarly, I find that the cut to Mr Winwood's foot played no material part in his cause of death. Dr Ritchey had the inestimable advantage of examining Mr Winwood's body shortly after his death. He was clear in his opinion that, despite the appearance of a lot of blood, the foot injury did not penetrate any major veins. His observation that the trail of blood without attempts to stem the flow being consistent with a state of delirium, is compelling. It is likely that Mr Winwood was moving around with his injured leg affected by substances rather than dying of hypovolemic shock from the laceration.
665. Dr Duflou was unwilling to exclude contributory factors, also embracing hypothermia as an alternative hypothesis which he had not previously considered. Dr Duflou referred to "*effects of medication*" as a factor amongst his list that could neither be excluded nor isolated as a causal factor.
666. By "*effects of medication*" I assume that Dr Duflou is referring to the reported fatal levels of methadone along with benzodiazepines, olanzapine and pregabalin that were detected as a result of toxicological analysis of postmortem blood samples taken at autopsy by Dr Ritchey. If this is the case, then respectfully, to place that cause last in a list after other more speculative causes (such as hypovolemic shock and alcohol withdrawal seizure where no direct evidence exists), is apt to mislead.
667. I should also deal with a final matter raised by Dr Duflou in his report.<sup>458</sup> He stated:

*"It appears to be unclear whether the blood found at the scene originated from the deceased, and no DNA comparison testing was done – such testing could confirm the origin of the blood."*

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<sup>457</sup> I also accept Dr Brett's opinion on the unlikelihood of alcohol withdrawal seizures. For example, see G1C page 10.

<sup>458</sup> G37i.

668. Again, with respect to Dr Duflou, there is evidence of a significant laceration to Mr Winwood's leg from which blood emanated. There is no evidence at all that the blood came from someone else or that another person was present at any relevant time. There was, and remains, no justification for DNA testing of the blood.
669. In conclusion, I am satisfied that Mr Winwood ingested excessive quantities of his prescription drugs, likely far greater quantities even than Dr Jackson directed. The combination of these sedative drugs resulted in CNS depression and, therefore, depression of the respiratory system causing death.<sup>459</sup>
670. I find that it is a plausible hypothesis that positional asphyxia was the final cause or mechanism of death in circumstances whereby Mr Winwood's respiratory system was already compromised by drug toxicity.
671. In this scenario, whilst under the influence of drugs and possibly already in a state of reduced consciousness, he may have moved to his final position in the footwell of the caravan. There, he was unable to protect his airway.

### *Conclusions regarding Mr Winwood's death*

672. In his reports and evidence for court, Dr Brett provided a thorough analysis of the major deficiencies in Dr Jackson's prescribing and treatment of Mr Winwood. <sup>460</sup> Many of them will already be apparent from the treatment of Mr Winwood described above; as well as my findings and comments about his gross departures from safe treatment in respect of the other three deceased.
673. The main areas of Dr Jackson's deficient treatment were considered by Dr Brett to be as follows:
- Uncontrolled prescribing of multiple sedating agents in a patient known to have benzodiazepine disorder;

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<sup>459</sup> CMW7. Relevantly, the forensic toxicologist reported: "*All opioids produce depression of the respiratory centres with normal analgesic doses – i.e. there is a decrease in rate and depth of breathing. The respiratory depression is affected by the conscious state - i.e. persons awake and in pain are less likely to develop respiratory depression than those asleep. It is reported that common pathological findings in opioid deaths include signs of respiratory depression and associated hypoxia, particularly in deaths with some delay. In combination with other central nervous system (CNS) depressants (e.g. pregabalin, olanzapine, oxazepam and temazepam), there is a risk of CNS depression, and the respiratory depressant effects of methadone will be enhanced. It has been recognised that many cases of methadone-induced death are not attributable to methadone alone, but to the combined effects of methadone and another drug or drugs.*"

<sup>460</sup> Reports G1-A, G1-B and G1-C.

- Commencing Mr Winwood's prescribing with four weekly takeaway doses (two lots of two consecutive doses).
- Continuing to prescribe inappropriately high numbers of methadone takeaway doses despite Mr Winwood's known instability, known overdoses on sedative medication, known alcohol abuse, antisocial behaviours and a history of doctor shopping.
- Prescribing five takeaway doses per week following Mr Winwood's release from prison in July 2014, and in doing so, failing to recognise his high risk of overdose and death upon release.
- Prescribing the opioid Endone for a prolonged period without controlled dispensing, and without an authority from PSB in breach of the *Poisons Act*.
- No utilisation of DORA, the real-time prescription monitoring system, despite Mr Winwood having a known history of prescription shopping.
- Continuing to prescribe benzodiazepines despite lack of stability and the particularly high risks associated with combining benzodiazepines with methadone.
- No attempts made to wean Mr Winwood what from benzodiazepines and no evidence of controlled dispensing, such as weekly supplies of his sedative medication.
- Circumventing the usual ORT restrictions by applying to switch Mr Winwood's methadone syrup to physeptone tablets.
- Failing to treat Mr Winwood's alcohol dependence.

674. In their closing submissions, counsel assisting well summarised Dr Jackson's evidence. His answers had little credibility other than to confirm that his approach to prescribing was based upon the proposition that patients should be accepted upon their word alone and they should be provided with the medications they request. Dr Jackson's evidence in respect of Mr Winwood's case appeared flippant and quite uncaring. For example, he said repetitively in his affidavit that he believed Mr Winwood would have died sooner "*on the street*" if he hadn't treated him.

675. He also gave evidence at inquest revealing his fatalistic view of Mr Winwood's

future, stating:

*“...Matthew in many ways was a hopeless case, that’s why he was being expelled from the Alcohol and Drug Service. Their opinion was that he was too difficult to manage so it was better that he went off and died somewhere else or under someone else’s watch. I took him on...”*

676. Some of the specific evidence given by Dr Jackson was as follows:

677. He was not aware that Mr Winwood injected his methadone at any time that he was treating him;

- He did not see Mr Winwood intoxicated with alcohol;
- Mr Winwood had long periods of stability;
- It was necessary that he prescribed the numerous (sedative) medications order to control Mr Winwood’s pain, and did not restrict or stage his supply;
- He did not reduce Mr Winwood’s benzodiazepines because it was not safe to do so;
- He prescribed Mr Winwood six takeaway doses of methadone per week because he was “living in the bush” and he did not have a driver’s licence;
- He did not smell alcohol on Mr Winwood alcohol when he saw him on 31 July 2017;
- He could not prescribe naltrexone to Mr Winwood for alcohol dependence because that drug would counteract is methadone; and
- He did not refer to Winwood to pain management treatment or counselling.

678. It would now be apparent from my comments and findings in respect of Dr Jackson, that I found his evidence to lack rationality, and also to lack remorse and insight into his serious failings in respect of his patients. Despite multiple opportunities in evidence, he remained hostile towards suggested criticism and was unwilling or unable to calmly and thoughtfully analyse matters put to him as potential deficiencies in his practice.

679. During the time Mr Winwood was treated by Dr Jackson he was given a regime of medications including many CNS depressant medications which increased over time. Dr Jackson could not have possibly been satisfied as to his stability. As submitted by counsel assisting, it was patently clear that Mr Winwood did not ever satisfy the test of being clinically stable so as to be eligible for takeaway doses of methadone and large quantities that of other prescribed sedatives. I have no doubt that Dr Jackson was aware that Mr Winwood abused alcohol chronically and at dangerous levels. I had the distinct impression after the totality of his evidence at inquest that he did not care sufficiently for his patients to ensure that they were as safe as possible.
680. Evidence was given to suggest that Mr Winwood's mother in fact contacted Dr Jackson to raise the issue and the fact that Mr Winwood was abusing his medication by injecting it or taking more than was prescribed. However, there is no evidence of any change in Dr Jackson's prescribing of Mr Winwood. This is the case even despite the occurrence of the deaths of Mr Brown, Ms Wiki and Ms Kemp.
681. Again, it is acknowledged that Dr Jackson did not prescribe or authorise the methadone to be taken by Mr Winwood intravenously and nor did he authorise him to take more of any of the drugs at one time than how it was prescribed to him.
682. However, it is clear from Mr Jackson's notes and his evidence that he did not conduct the necessary assessments and reviews to ensure Mr Winwood's stability. He was clearly not stable. The need to ensure stability before allowing takeaways is due to the risk of the patient overdosing by using more of the medication than prescribed or injecting it. Despite this Dr Jackson authorised the significant take away doses and an unlimited supply of sedative medications.
683. I am satisfied that Dr Jackson, by prescribing what was a very large quantity supply of CNS depressants, played a causative role in still Winwood's death. I am positively satisfied that if Mr Winwood had not received from Dr Jackson what was effectively an unlimited supply for a drug binge, he would not have died. He may have died by drug overdose eventually, such was his high risk, but that is not to the point. He was deprived of a chance to live at that time.

## Conclusions on Scope of inquest

684. I have made findings and comments regarding the circumstances of each death and the contribution of drug toxicity. I have also made findings concerning the role of other persons in the circumstances of death and whether any actions or omissions by them were causal, contributory or connected to any of the four deaths. In accordance with the scope, the above findings and comments have focused upon the role of Dr Jackson as the medical practitioner delivering ORT to each of the deceased prior to their death.
685. Mr Brown, Ms Wiki, Ms Kemp and Mr Winwood, all struggling with substance use disorder, were most vulnerable people. They had reduced ability to protect their own wellbeing and were at greatly increased risk of harm because of their illness. Quite tragically, their decision-making and actions were causative of their own deaths in various ways. However, as discussed at length, other causal factors were also present.
686. I now formally record findings and comments against the each of the five points comprising the scope of the inquest. These should be read in conjunction with my preceding findings and comments.

### *Scope point (1)*

The matters required for finding under section 28(1) (a)-(d) of *the Coroners Act 1995*, and, specifically in relation to cause of death, the contribution of methadone and other drugs to the death of each of the deceased;

687. Regarding **Nicholas Shane Brown**, I formally find pursuant to section 28(1) that:
- a) The identity of the deceased is Nicholas Shane Brown, date of birth 29 July 1981;
  - b) Mr Brown died unintentionally in the circumstances set out in this finding;
  - c) The cause of Mr Brown's death was combined drug (methadone and benzodiazepine) intoxication; and
  - d) Mr Brown died on 27 September 2016 at New Town in Tasmania.

688. Regarding **Toni Lee Wiki**, I formally find pursuant to section 28(1) that:
- a) The identity of the deceased is Toni Lee Wiki, date of birth 10 August 1978;
  - b) Ms Wiki died unintentionally in the circumstances set out in this finding;
  - c) The cause of Ms Wiki's death was cardiac arrest as a result of foreign body granulomas caused by injecting one or more crushed Xanax pills; and
  - d) Ms Wiki died on 14 February 2017 at Hobart in Tasmania.
689. Regarding **Belinda Emma Kemp**, I formally find pursuant to section 28(1) that:
- a) The identity of the deceased is Belinda Emma Kemp, date of birth 28 March 1980;
  - b) Ms Kemp died unintentionally in the circumstances set out in this finding;
  - c) The cause of Ms Kemp's death was community-acquired pneumonia. Mixed drug toxicity, emphysema, obesity and dilated cardiomyopathy all contributed to her cause of death; and
  - d) Ms Kemp died between 5 and 6 July 2017 at Bridgewater in Tasmania.
690. Regarding **Matthew Wayne Winwood**, I formally find pursuant to section 28(1) find that:
- a) The identity of the deceased is Matthew Wayne Winwood, date of birth 28 September 1969;
  - b) Mr Winwood died unintentionally in the circumstances set out in this finding;
  - c) The cause of Mr Winwood's death was mixed prescription drug toxicity (methadone, olanzapine, pregabalin, benzodiazepines); and
  - d) Mr Winwood died between 3 and 4 August 2017 at Rhyndaston in Tasmania.

*Scope point (2)*

Consideration of TOPP guidelines, legislation and policies in place at the time of the deaths, and currently, as connected to one or more of the deaths

691. Chief Pharmacist, Peter Boyles, assisted the inquest with comprehensive written and oral evidence. Relevantly, he explained the role of PSB in monitoring and regulating the prescription and dispensing of opioid pharmacotherapy.<sup>461</sup>
692. Mr Boyles had been employed with PSB since 2002 and, from 2015, occupied the role of Chief Pharmacist. He was involved in the development of the TOPP guidelines, although Dr Reynolds as Director of ADS was the principal author of the TOPP.
693. From the evidence of Mr Boyles, it is clear that the regulation of opioid pharmacotherapy by PSB is centred around adherence to the TOPP guidelines. He confirmed in evidence that they should be strictly adhered to, where possible. He said that the guidelines remained fit for purpose, particularly in relation to takeaway provisions. I did not take him to indicate that it was not desirable to make improvements to enable contemporary delivery of ORT.
694. Mr Boyles was of the view that a high proportion of those receiving takeaway doses should not be in receipt of them, because they are not clinically stable and appropriate assessments have likely not taken place. His view accords with the findings of coroners in Tasmania.
695. Mr Boyles said that if PSB was notified of a prescriber who was not complying with the conditions of the authority, it would contact the prescriber to discuss, and possibly refer them to ADS for further clinical discussions. If that process was unsuccessful, the prescriber would likely be referred to AHPRA, and PSB would consider revoking the authority.<sup>462</sup>
696. Whilst I acknowledge that PSB provide very helpful regulatory assistance to prescribers and pharmacists, I have seen little evidence over the years of PSB revoking authorities, or referrals to other bodies in more serious cases. Mr Boyles said that improved compliance monitoring would need to be aided by ongoing education of prescribers to ensure that they understand the requirements of their authority and the TOPP.
697. As regulator, PSB must enforce compliance. However, it is plain upon the evidence that PSB has insufficient staff and resourcing to be able to investigate breaches by prescribers in any meaningful way, let alone to refer appropriate

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<sup>461</sup> T1450 – 1544, G26 and G39.

<sup>462</sup> G26.

cases for investigation, prosecution or disciplinary action. Of course, the instigation of action (in various forms) is also critical for the purpose of deterring others who may be non-compliant with legislation or guidelines designed to protect the safety of patients and the community. When prescribers do not perceive that they are accountable for breaches, the standards cannot achieve what they are designed to do.

698. I comment that it is *critical* that PSB is resourced to investigate potential breaches of the *Poisons Act*, regulations and guidelines if it is to fully achieve its function of regulating the safe, lawful supply and use of medicines (and in particular, Schedule 8 medicines.)
699. I comment that the Tasmanian government should consider resourcing PSB appropriately to enable it to adequately fulfill its enforcement role.
700. Dr Nicolle Ait Khelifa, Director of ADS, explained in evidence that ADS has a clinical role in respect of ORT, rather than a regulatory role. It manages the public patients receiving ORT, and the TOPP guidelines represent the proper standards to guide treatment.
701. She confirmed that ADS has no role in managing compliance with the TOPP for private patients, although it provides advice and support to private prescribers.
702. Again, from all of the evidence at inquest, I can safely make a finding that ADS is inadequately resourced to optimise its delivery of ORT. There are unacceptably long waiting lists and insufficient nurses and case managers.<sup>463</sup>
703. Dr Ait Khelifa further indicated that, in Tasmania, more prescribing practitioners were needed, and additional resources to train and support them. This would relieve pressure on ADS and expedite delivery of ORT to public patients.
704. Dr Ait Khelifa endorsed the role of the TOPP as setting the standards for ORT in Tasmania. She described some potential changes, including adding flexibility to some standards. She also described the prospect of delivering the safer “*depot buprenorphine*” by fortnightly or monthly injection instead of daily pharmacy dosing. Dr Ait Khelifa was strongly of the view, like Dr Brett, that there is only a very limited role for prescribing benzodiazepines with pharmacotherapy due to the unacceptably high risks to patients.

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<sup>463</sup> At the time of Dr Ait Khelifa giving evidence.

705. The pharmacists involved in this inquest were trained in and were familiar with the important requirements of the TOPP so far the standards dealt with the requirements for safe dispensing.<sup>464</sup> As a group, I found them to have a strong awareness of the high risks inherent in prescribing and dispensing.
706. Mr Ziegler, the senior pharmacist dispensing to PX, was knowledgeable in the TOPP guidelines and clearly was of the view that they should be followed. He said that private doctors tend to use their own discretion and some may disregard the guidelines. Ms Gillie, also, was guided by the provisions of TOPP in making her report to PSB of excessive takeaway doses prescribed by Dr Jackson to Mr Brown in the year of his death.
707. I reject the evidence of Dr Jackson that the TOPP guidelines did not have force and that they were simply developed as a document for use by ADS. This view is extremely concerning, and contrary to the views of almost every other professional witness giving evidence at the inquest. Naturally, there has been some criticism of the guidelines, both at their implementation and subsequently because of their perceived inflexibility.
708. A significant amount of work on the TOPP review has already been completed. There is evidence of the existence of an overview report submitted to ADS by the TOPP Review Project Officer (former Tasmanian Chief Pharmacist, Jim Galloway). However, there was evidence at inquest that the Project Officer's role was withdrawn following a fixed term appointment which ended in April 2019. It seems that this report is still with ADS and includes a number of key recommendations to amend, update and improve the TOPP document and the operation of the program.

### *Scope point (3)*

The role of those involved in the administration of opioid pharmacotherapy or prescription of methadone and other medications to each of the deceased as connected to the death, including prescribing doctors, nurses and dispensing pharmacists, with reference to the TOPP and relevant legislation and requirements for such administration.

709. I have dealt with this point of scope under *Scope point (2)* above.

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<sup>464</sup> Ms Steinberg was only aware of the former guidelines.

*Scope point (4)*

Consideration of the role or functions of Pharmaceutical Services Branch and Alcohol and Drug Service in the opioid pharmacotherapy program, as connected to one or more of the deaths

710. I have dealt with this point of scope under *Scope point (2)* above.

*Scope point (5)*

The contribution, if any, of those involved in the administration of pharmacotherapy, prescription of methadone and other medications to the cause of death of any of the deceased

711. I summarise briefly the conclusions discussed in detail in this finding:

1. The actions of Dr Jackson, by his grossly irresponsible prescribing, played a direct causative role in the deaths of Mr Brown and Mr Winwood. He did not play a direct role in the deaths of Ms Wiki or Ms Kemp. I have made adverse comment in respect of Dr Jackson in respect of the dangerous manner of his treatment and prescribing in respect of Mr Brown, Mr Winwood, Ms Wiki and Ms Kemp.
2. Mr Jacometti did not play a direct causative role in any of the four deaths. However, I have made adverse comment in respect of Mr Jacometti in assisting and enabling Dr Jackson's aberrant practice of pharmacotherapy and in respect of his lack of knowledge of pharmacotherapy generally and lack of knowledge of the TOPP guidelines. I have made particularly adverse comments in respect of Mr Jacometti's role in the circumstances surrounding the death of Mr Brown.
3. None of the dispensing pharmacists played any role, direct or indirect, in any of the four deaths. I have not made adverse comment in respect of the pharmacists.
4. I have made no significant adverse findings or comments regarding the role of the Salvation Army in its capacity as provider of the room from which Dr Jackson worked or provider of services to three of the deceased. It could not have foreseen that Dr Jackson's prescribing so grossly departed from appropriate standards that his patients were at risk. As employer of Mr Jacometti, *and in hindsight only*, the Salvation Army may have exercised greater supervision over Mr Jacometti when he

commenced working with Dr Jackson in order to understand the nature of his role, whether he was qualified to perform the duties and the manner in which the patient information he obtained would be shared with the Salvation Army for the benefit of the mutual patients. However, the Salvation Army could not have foreseen that Dr Jackson would deliver ORT to Salvation Army clients no regard to applicable standards.

I comment that the Salvation Army has taken positive steps regarding the area of case-note recording and employment of a national nurse supervisor.

## **Final Comments**

### *Coronial data and previous coronial findings*

712. At my request, the Senior Research Officer within the Coronial Division extracted data from the Death Surveillance system relating to deaths caused by drug toxicity from the period 2018-2025. The deaths the subject of the request comprised pharmaceutical and illicit drug-induced overdose deaths (including alcohol) where the acute toxic effects of drugs were the primary cause of death or significant contributory cause. Over this 8-year period, there were 38 deaths per year in this category. It is noted that a proportion of these deaths were intentional.
713. In 2018, the Coronial Division undertook significant work to establish an overdose deaths register. Resourcing issues did not permit the continuation of this important development. Like the established suicide register, the re-establishment of the register relating to overdose deaths would enable in-depth analysis of the investigation material to inform well-founded prevention strategies.<sup>465</sup>
714. In the last 15 years, coroners delivering multiple findings have consistently emphasised that medical practitioners prescribing methadone or other Schedule 8 drugs must exercise heightened vigilance due to the significant risk of diversion, overdose and community harm.
715. In many findings, coroners have recognised the therapeutic value of ORT but have repeatedly observed that takeaway methadone doses are frequently linked to unintentional overdose deaths, including deaths of individuals to whom the

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<sup>465</sup> [Steer,-Michael-Allan.pdf](#) at page 8.

medication had not originally been prescribed.<sup>466</sup> As mentioned, this cohort comprises vulnerable persons with complex histories of substance dependence and polysubstance use.

716. Over a long period, coroners have made particular comments regarding the need for prescribing medical practitioners to adhere to the TOPP guidelines. Consistently, coroners have stressed that takeaway doses should remain the exception rather than the routine, and that methadone should be consumed under the direct supervision of a pharmacist. Many findings have emphasised the dangers of intravenously injecting methadone syrup and the high risk of abuse and illicit diversion.

717. Tasmanian coronial findings continue to emphasise that prescribing medical practitioners should:

- Carefully assess clinical stability before authorising takeaway doses;
- Continually reassess patient risk factors;
- Document risk-benefit analyses when departing from guidelines;
- Monitor changes in domestic, social and behavioural circumstances; and
- Seek advice from Alcohol and Drug Services where uncertainty exists.

718. Recommendations from coroners regarding monitoring and oversight included:

- Establishing better systems for identifying inappropriate prescribing;
- Enhancing communication between general practitioners, mental health services and Alcohol and Drug Services; and
- Creating medical review bodies to review high-risk prescribing and prescription-related deaths.

719. Many findings acknowledged the time-intensive and complex task for medical practitioners in managing patients with chronic pain, opioid dependence, mental

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<sup>466</sup> A small selection of findings are:  
*Reynolds, Chrystal – 2011 TASCDC 249.*  
*Steer, Marianne – 2020 TASCDC 250.*  
*Lowe, Paul – 2021 TASCDC 684.*  
*Arnold, Derek – 2020 TASCDC 309.*  
*Wellington, Timothy John – 2020 TASCDC 474.*  
*Steer, Michael-2018 TASCDC 316.*

illness, social instability, and polysubstance use. This is especially the case for rural or sole medical practitioners who may not have clinical support or the ability to make referrals

720. Coroners have strongly supported implementation and strict adherence to the TOPP guidelines, which include supervised dosing as the standard approach; limited access to takeaway doses; detailed clinical risk assessments; mandatory review of patient stability; regular urinalysis; withdrawal of takeaway privileges where risks arise; and prescribing only in accordance with the conditions of a current Section 59E authority.
721. Finally, it is relevant to note that the previous real-time prescription monitoring system, DORA, has been replaced with *TasScript* which monitors a wider range of high-risk medicines.
722. In 2022, ahead of the introduction of *TasScript*, the *Poisons Regulations 2018* were amended to, relevantly, include regulation 95B “*monitored medicines*” category, including, relevantly, benzodiazepines, olanzapine, codeine, pregabalin and quetiapine.<sup>467</sup>
723. There is a mandatory associated obligation imposed upon prescribers pursuant to section 38G of the *Poisons Act* requiring prescribers to take all reasonable steps before prescribing a monitored medicine to a person, to check the monitored medicines database, *TasScript*, for information in relation to the person. The penalty for breach of this section is a fine. However, if a prescriber breaches the section by not taking such reasonable steps, then there is a breach also of their professional duty which may have other disciplinary consequences.
724. *TasScript*, introduced in 2024, is a clinical decision support tool which provides prescribers and pharmacists access to real-time information regarding a patient’s monitored medicines history so they can make more informed decisions regarding the supply of these medicines.
725. *TasScript* closely follows the Victorian system, *SafeScript*, which has been mandatory for Victorian prescribers since 2020. A significant Victorian coronial finding recorded that, despite prescriber checking being mandatory, only 70% of prescribers are compliant. This low compliance rate is most concerning and I

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<sup>467</sup> Statutory Rule 28 of 2022.

comment that those overseeing the operation of *TasScript* should be vigilant in achieving the aim of compliance by all Tasmanian prescribers.<sup>468</sup>

### Recommendations

- (a) I **recommend** that, Department of Health (ADS) completes its review of the TOPP guidelines (2012) with due regard to the considerable body of work already completed; and, following consultation with relevant medical professionals and other stakeholders, complete the new TOPP guidelines as soon as possible.
- (b) I **recommend** that, at the commencement of the new TOPP guidelines, the Department of Health (PSB and ADS) widely promote the implementation of the guidelines to prescribers and pharmacists and, in doing so, emphasise that the guidelines set out the required standards for delivery of ORT in this state.
- (c) I **recommend** that the Department of Health (PSB) reviews its processes for identifying and investigating breaches or potential breaches by prescribers of the *Poisons Act*, regulations and relevant guidelines (including TOPP guidelines); and develop a robust strategy to refer breaches by prescribers in appropriate cases for prosecution or to AHPRA.
- (d) I **recommend** that the Department of Health and/or Department of Justice<sup>469</sup> reviews the adequacy of the exchange of information between the prison(s) and community health professionals regarding a prisoner's prescribed medications, particularly prisoners entering and being released from the prison who are participating in ORT; and I further recommend that such review also considers the adequacy of existing processes and procedures for obtaining the consent of a prisoner to share their information with all relevant treating health professionals.
- (e) I **recommend** that the Department of Health employs within ADS a sufficient number of case managers, nurses and educators to enable ADS to serve the community's requirements for ORT to be delivered within the public system, as well as enhancing its ability to provide clinical support to private ORT providers.
- (f) I **recommend** the Department of Health create within PSB of a position of Outreach Clinical Educator or similar to provide outreach clinical support to

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<sup>468</sup> [Finding into death with Inquest - COR 2019 0537 - for publication.pdf](#).

<sup>469</sup> The agencies being Correctional Primary Health Services and/or Tasmania Prison Service.

prescribers and dispensers, the functions of that position to include education of prescribing doctors, pharmacists and others regarding appropriate practice for prescribing of Schedule 8 and Schedule 4 drugs of a high abuse potential; and to encourage the mandatory use of *TasScript* by prescribers and reinforce its value as a clinical tool.<sup>470</sup>

- (g) I **recommend** that the Department of Health, following an appropriate period of the operation of *TasScript*, review compliance by prescribers with the obligation to check *TasScript*; and, if necessary, take measures to enforce compliance.
- (h) I **recommend** that PSB considers the merits of requiring applicants for Section 59E authorities to provide more comprehensive patient information for the purpose of PSB assessing the application to prescribe; and I further recommend that PSB reviews the adequacy of its standard terms for Section 59E prescribing authorities and considers whether additional, and stricter, conditions should be imposed routinely upon prescribers in cases of particularly high risk.
- (i) I **recommend** that the Department of Health develops enhanced systems of incentivisation and training to medical practitioners to be involved in the practice of ORT.
- (j) I **recommend** that AHPRA disseminate this finding to its relevant branches across Australia and to the Medical Board of Australia for retention and consideration in the event that David Jackson, former medical practitioner, seeks re-registration as a medical practitioner.

### **Acknowledgements**

726. I appreciate the assistance given by counsel assisting, Emily Bill, Letitia Fox and Alison Shand (deceased).

727. I also acknowledge the dedicated work over a lengthy period by Detective Senior Constables Tami Nelsen, Andrew Bovill and Kathryn Barwick<sup>471</sup> in their investigation of outstanding quality.

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<sup>470</sup> I previously made an almost identical recommendation in 2018 in the matter of Steer,- Michael-Allan.pdf, although there is no evidence that it has been implemented.

<sup>471</sup> Now Sergeant.

728. I convey my sincere condolences to the family and loved ones of Mr Brown,  
Ms Wiki, Mr Winwood and Ms Kemp.

**Dated:** 3 June 2026 at Hobart, in the State of Tasmania

**Olivia McTaggart**  
**Coroner**



MAGISTRATES COURT of TASMANIA  
CORONIAL DIVISION

**LIST OF EXHIBITS**

**Record of investigation into the death of Nicholas  
Shane Brown**

No.	TYPE OF EXHIBIT	NAME OF WITNESS
<b><u>FOLDER 1</u></b>		
<b>CNB1</b>	<b>REPORT OF DEATH</b>	<b>CONSTABLE DOUGLAS</b>
<b>CNB2</b>	<b>LIFE EXTINGUISHED AFFIDAVIT</b>	<b>DR M ROGERS</b>
<b>CNB3</b>	<b>AFFIDAVIT OF IDENTIFICATION</b>	<b>SENIOR CONSTABLE KEYGAN</b>
<b>CNB4</b>	<b>MORTUARY AFFIDAVIT</b>	<b>ANTHONY CORDWELL</b>
<b>CNB5</b>	<b>POST MORTEM REPORT</b>	<b>DR CHRISTOPHER LAWRENCE</b>
<b>CNB5a</b>	<b>&amp; INTERIM REPORT</b>	
<b>CNB5b-d</b>	<b>AUTOPSY PHOTOGRAPHS</b>	
<b>CNB6</b>	<b>TOXICOLOGY REPORT</b>	<b>DR MIRIAM CONNOR</b>
<b>CNB7</b>	<b>MEDICAL REPORT</b>	<b>AMBULANCE TASMANIA</b>
<b>CNB8</b>	<b>MEDICAL RECORDS</b>	<b>THS - ROYAL HOBART HOSPITAL</b>
<b>CNB9b-d</b>	<b>MEDICAL &amp; CLIENT RECORDS</b>	<b>CORRECTIONAL HEALTH/ MENTAL HEALTH &amp; STATEWIDE SERVICES</b>
<b>CNB10a-n</b>	<b>MEDICAL RECORDS</b>	<b>DR DAVID JACKSON</b>
<b>CNB11a,b,e &amp; f-w</b>	<b>MEDICAL REPORT &amp; CLIENT RECORDS</b>	<b>DHHS - PHARMACEUTICAL SERVICES BRANCH</b>
<b>CNB12a-b</b>	<b>MEDICAL RECORDS</b>	<b>THE HOBART CLINIC</b>
<b>CNB13a-f</b>	<b>CLIENT RECORDS</b>	<b>MEDICARE</b>

<b>CNB14</b>	<b>MEDICAL RECORDS - McCOY</b>	<b>CLARENCE GP SUPERCLINIC</b>
<b>CNB15a-b</b>	<b>MEDICAL RECORDS &amp; EMAIL</b>	<b>NSW Ministry of Health - LEGAL &amp; REGULATORY SERVICES BRANCH</b>
<b>CNB16ai-iii &amp; 16e</b>	<b>CLIENT RECORDS</b>	<b>SALVATION ARMY BRIDGE CENTRE</b>
<b>CNB17a-b</b>	<b>PHARMACY RECORDS &amp; EMAIL</b>	<b>DAVEY STREET DISCOUNT PHARMACY</b>
<b>CNB18a-d</b>	<b>PHARMACY RECORDS</b>	<b>GUARDIAN ELIZABETH STREET PHARMACY</b>
<b>CNB19 Records 2014-2015</b>	<b>PHARMACY RECORDS</b>	<b>LENAH VALLEY AMCAL PHARMACY</b>
<b>CNB20 Dosing history 2005-July 2016</b>	<b>PHARMACY RECORDS</b>	<b>NORTH HOBART PHARMACY</b>
<b>CNB21a-s</b>	<b>PHARMACY RECORDS</b>	<b>WEST HOBART AMCAL PHARMACY</b>
<b>CNB22</b>	<b>PHARMACY RECORDS - McCOY</b>	<b>WEST HOBART AMCAL PHARMACY</b>
<b>CNB23</b>	<b>CLIENT RECORDS</b>	<b>QLD ADS RECORD</b>
<b>CNB24 pp. 2,3,4 &amp; 6.</b>	<b>MEDICAL RECORDS</b>	<b>ABORIGINAL HEALTH SERVICE</b>
<b>CNB25</b>	<b>Not Used</b>	
<b>CNB26a-ta</b>	<b>PRISON ARUNTA CALLS (DISC) &amp; SUMMARY OF CALLS</b>	<b>RISDON PRISON &amp; TASMANIA POLICE</b>
<b><u>FOLDER 2</u></b>		
	<b><u>WITNESSES</u></b>	
<b>NB1</b>	<b>STATUTORY DECLARATION</b>	<b>SNOK - MELISSA McCOY – dated 27/9/2016</b>
<b>NB2</b>	<b>STATUTORY DECLARATION</b>	<b>SNOK - MELISSA McCOY – dated 10/11/2016</b>

<b>NB3</b>	<b>INTERVIEW (DISC &amp; TRANSCRIPT)</b>	<b>MELISSA McCOY – dated 14/12/2016</b>
<b>NB4</b>	<b>INTERVIEW (DISC)</b>	<b>MELISSA McCOY – dated 16/6/2019</b>
<b>NB5</b>	<b>STATUTORY DECLARATION</b>	<b>MELISSA McCOY – dated 23/6/2019</b>
<b>NB6</b>	<b>AFFIDAVIT</b>	<b>WILLIAM BROWN – dated 28/11/2016</b>
<b>NB7</b>	<b>STATUTORY DECLARATION</b>	<b>WILLIAM BROWN – dated 30/1/2020</b>
<b>NB8</b>	<b>AFFIDAVIT</b>	<b>CAROL BROWN – dated 29/11/2016</b>
<b>NB9</b>	<b>AFFIDAVIT</b>	<b>CINDY BAKER – dated 27/4/2017</b>
<b>NB10</b>	<b>STATUTORY DECLARATION</b>	<b>CINDY BAKER – dated 7/5/2020</b>
<b>NB11</b>	<b>STATUTORY DECLARATION</b>	<b>MICHELLE GORDON – dated 27/5/2019</b>
<b>NB12</b>	<b>STATUTORY DECLARATION</b>	<b>GEMMA HAY – dated 6/5/2020</b>
<b>NB13</b>	<b>AFFIDAVIT</b>	<b>DR DAVID JACKSON – dated 17/2/2017</b>
<b>NB14</b>	<b>Not Used</b>	
<b>NB15</b>	<b>AFFIDAVIT</b>	<b>NIKOLAAS AZON- JACOMETTI dated 27/3/2017</b>
<b>NB16</b>	<b>INTERVIEW &amp; TRANSCRIPT</b>	<b>NIKOLAAS AZON-JACOMETTI subject to redactions</b>
<b>NB17</b>	<b>AFFIDAVIT &amp; ATTACHMENT</b>	<b>DR ADRIAN REYNOLDS – dated 24/8/2018</b>
<b>NB18</b>	<b>STATUTORY DECLARATION</b>	<b>DR ANNA MCKINLAY – dated 17/4/2020</b>
<b>NB19 NB19 a NB19 b</b>	<b>AFFIDAVIT &amp; ANNEXURES &amp; PHP RECORD APPENDIX B</b>	<b>DR CHRIS WAKE – dated 15/8/2018</b>
<b>NB20</b>	<b>STATUTORY DECLARATION</b>	<b>DR CHRIS WAKE – dated 10/1/2020</b>
<b>NB21</b>	<b>STATUTORY DECLARATION</b>	<b>OLIVIA GILLIE – dated 17/5/2019</b>
<b>NB22</b>	<b>AFFIDAVIT</b>	<b>ANTON BARTULOVIC – dated 17/3/2017</b>
<b>NB23</b>	<b>AFFIDAVIT</b>	<b>AIMEE TURNER – dated 3/3/2017</b>

<b>NB24</b>	<b>AFFIDAVIT &amp; ANNEXURES</b>	<b>CONAN ZIEGELER – dated 15/8/2018</b> Duplicated – at G16-39
<b>NB25</b>	<b>AFFIDAVIT &amp; ANNEXURES</b>	<b>MARY COOK – dated 21/8/2018</b>
<b>NB26</b>	<b>AFFIDAVIT &amp; ANNEXURES</b>	<b>MICHAEL NASH – dated 22/8/2018</b>
<b>NB27</b>	<b>AFFIDAVIT</b>	<b>DEBRA BELL – dated 13/2/2018</b>
<b>NB28</b>	<b>AFFIDAVIT</b>	<b>AMANDA QUEALEY – dated 13/2/2018</b>
<b>NB29</b>	<b>AFFIDAVIT</b>	<b>PENELOPE CHUGG – dated 9/2/2018</b>
<b>NB30</b>	<b>AFFIDAVIT</b>	<b>PENELOPE CHUGG – dated 25/5/2020</b>
<b>NB31</b>	<b>STATUTORY DECLARATION</b>	<b>DANIELLE COOPER – dated 12/12/2019</b>
<b>NB32</b>	<b>STATUTORY DECLARATION</b>	<b>RICHARD LENNON – dated 16/3/2020</b>
<b>NB33</b>	<b>STATUTORY DECLARATION</b>	<b>JACKIE MOLNAR – dated 15/4/2020</b>
<b>NB34</b>	<b>STATUTORY DECLARATION</b>	<b>QUINN BISSETT – dated 15/4/2020</b>
<b>NB35</b>	<b>STATUTORY DECLARATION</b>	<b>PETER BOYLES – dated 4/1/2021</b>
<b>NB36</b>	<b>STATUTORY DECLARATION</b>	<b>SAM HALLIDAY – dated 12/5/2020</b>
<b>NB37</b>	<b>STATUTORY DECLARATION</b>	<b>DANICA IVKOVIC – dated 29/5/2020</b>
<b>NB38</b>	<b>STATUTORY DECLARATION &amp; ANNEXURES</b>	<b>CLAY BUTLER – dated 21/1/2020</b>
<b>NB39</b>	<b>Not Used</b>	
<b>NB40</b>	<b>STATUTORY DECLARATION</b>	<b>CHRISTOPHER FALCKE – dated 10/6/2020</b>
<b>NB41</b>	<b>Not Used</b>	
<b>NB42</b>	<b>AFFIDAVIT</b>	<b>DARREN CONABEER – dated 28/8/2018</b>
<b>NB43</b>	<b>STATUTORY DECLARATION</b>	<b>CLIVE HODGETTS – dated 29/9/2016</b>
<b>NB44</b>	<b>STATUTORY DECLARATION</b>	<b>MELISSA DAVIDSON – dated 23/3/2020</b>
<b>NB45</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SENIOR CONSTABLE LOWE – dated 9/11/2016</b>
<b>NB46</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SENIOR CONSTABLE LOWE – dated 7/12/2017</b>
<b>NB47 &amp; NB47a</b>	<b>AFFIDAVIT &amp; PROPERTY RECEIPT</b>	<b>DETECTIVE SENIOR CONSTABLE NELSEN – dated 8/11/2016</b>

<b>NB48 &amp; NB48a</b>	<b>AFFIDAVIT &amp; DIAGRAM</b>	<b>SENIOR CONSTABLE KEYGAN – dated 16/11/2016</b>
<b>NB49</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE DOUGLAS – dated 5/11/2016</b>
<b>NB50</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE CONSTABLE BUGG – dated 31/10/2016</b>
<b>NB51</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE EVANS – dated 28/10/2016</b>
<b>NB52</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE JOHNSON – dated 31/10/2016</b>
<b>NB53a-ya</b>	<b>AFFIDAVIT &amp; PHOTOGRAPHS</b>	<b>CONSTABLE HYLAND – dated 23/12/2016</b>
<b>NB54</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE SHAW – dated 29/8/2018</b>
<b>NB55a-f</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE MORFFEY – dated 8/12/2020</b>
<b>FOLDER 3</b>		
<b>NB56b-f</b>	<b>STATUTORY DECLARATION &amp; ANNEXURES</b>	<b>DETECTIVE SENIOR CONSTABLE OWERS &amp; QUEENSLAND CORRECTIVE SERVICES</b>
<b>NB57</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SERGEANT WEBSTER – dated 13/1/2020</b>
<b>NB58</b>	<b>CCTV FOOTAGE (DISC) &amp; PHOTOGRAPHS</b>	<b>HILL STREET GROCER</b>
<b>NB59a-aa</b>	<b>000 CALLS (DISC &amp; TRANSCRIPT)</b>	<b>AMBULANCE TASMANIA &amp; TASMANIA POLICE</b>
<b>NB60a-c</b>	<b>MOBILE PHONE EXAMINATION &amp; RECORDS – McCOY</b>	<b>TASMANIA POLICE &amp; TELSTRA</b>
<b>NB61a-b</b>	<b>MOBILE PHONE EXAMINATION</b>	<b>TASMANIA POLICE</b>
<b>NB62</b>	<b>TELEPHONE (FAX LINE) RECORDS – SALVATION ARMY BRIDGE CENTRE</b>	<b>TELSTRA</b>

<b>NB63a-b</b>	<b>MOBILE PHONE RECORDS – DR JACKSON</b>	<b>TELSTRA</b>
<b>NB64a-b</b>	<b>MOBILE PHONE RECORDS – AZON-JACOMETTI</b>	<b>TELSTRA</b>
<b>NB65a-e</b>	<b>EMAILS</b>	<b>NIKOLAAS AZON-JACOMETTI</b>
<b>NB66a-i</b>	<b>DOCUMENTATION (DISC)</b>	<b>AHPRA</b>
<b>NB67</b>	<b>Priors – QLD</b>	<b>TASMANIA POLICE</b>
<b>NB68</b>	<b>Not Used</b>	
<b>NB69</b>	<b>Not Used</b>	
<b>NB70</b>	<b>Not Used</b>	
<b>NB71</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SENIOR CONSTABLE LOWE – dated 5/3/2018</b>
<b>NB72</b>	<b>AFFIDAVIT</b>	<b>SERGEANT PAUL</b>



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

### LIST OF EXHIBITS

## Record of investigation into the death of Toni Lee WIKI

No.	TYPE OF EXHIBIT	NAME OF WITNESS
CTW1	REPORT OF DEATH	CONST CARTER
CTW2	LIFE EXTINGUISHED AFFIDAVIT	DR PAUL SCOTT
CTW3	AFFIDAVIT OF IDENTIFICATION	CONST CASSIDY
CTW4	MORTUARY AFFIDAVIT	CONST CASSIDY
CTW5 & CTW5a-c	POST MORTEM AFFIDAVIT & AUTOPSY PHOTOGRAPHS	DR DONALD RITCHEY
CTW6	TOXICOLOGY REPORT	MIRIAM CONNOR
CTW7	MEDICAL REPORT	AMBULANCE TASMANIA
CTW8	MEDICAL RECORDS	DR EMIL DJAKIC PATRICK STREET CLINIC
CTW9a-b	MEDICAL RECORDS	THS – ROYAL HOBART HOSPITAL (DISC)
CTW10a- b	MEDICAL RECORDS	ADS
CTW11a- b	MEDICAL RECORDS	HOBART CLINIC
CTW12	MEDICAL RECORDS	DR SHAUNAGH JONES
CTW13a- e	MEDICAL RECORDS	DR RAJENDRA PRASAD
CTW14	MEDICAL RECORDS	DR ALEX SUTHERLAND
CTW15a- e	MEDICAL RECORDS	DR VICTOR WANG
CTW16a- u	MEDICAL REPORT & CLIENT RECORDS	DHHS – PHARMACEUTICAL SERVICES RECORDS

<b>CTW17a-h</b>	<b>PHARMACY RECORDS</b>	<b>NORTH HOBART AMCAL PHARMACY</b>
<b>CTW18a-d</b>	<b>CLIENT RECORDS</b>	<b>MEDICARE</b>
<b>CTW19</b>	<b>AFFIDAVIT</b>	<b>SNOK - GILLIAN FOWLER – dated 18/5/2017</b>
<b>CTW20</b>	<b>AFFIDAVIT</b>	<b>MARTIN QUIGLEY – dated 14/2/2017</b>
<b>CTW21</b>	<b>AFFIDAVIT</b>	<b>MARTIN QUIGLEY – dated 8/8/2017</b>
<b>CTW22</b>	<b>AFFIDAVIT</b>	<b>SKYE LITTLE – dated 3/7/2017</b>
<b>CTW23</b>	<b>AFFIDAVIT</b>	<b>JARED TUFFIN – dated 14/6/2017</b>
<b>CTW24</b>	<b>STAUTORY DECLARATION</b>	<b>DR SHAUNAGH JONES – dated 1/5/2020</b>
<b>CTW25 &amp; CTW25a</b>	<b>STATUTORY DECLARATION</b>	<b>DR RAJENDRA PRASAD – dated 10/6/2020</b>
<b>CTW26</b>	<b>AFFIDAVIT</b>	<b>CARRIE BURNS – dated 4/9/2018</b>
<b>CTW27</b>	<b>AFFIDAVIT</b>	<b>PETER CECYS – dated 11/9/2018</b>
<b>CTW28</b>	<b>AFFIDAVIT</b>	<b>ADAM McGARVIE – dated 18/10/2018</b>
<b>CTW29</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE FEATHERSTONE – dated 13/8/2017</b>
<b>CTW30</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE CASSIDY – dated 20/2/2017</b>
<b>CTW31</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE MITCHELL – dated 14/8/2017</b>
<b>CTW32</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE SCOTT – dated 30/4/2017</b>
<b>CTW33</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE CONSTABLE FRY – dated 14/3/2017</b>
<b>CTW34 &amp; CTW34a</b>	<b>AFFIDAVIT &amp; PROPERTY SEIZURE RECEIPT</b>	<b>DETECTIVE SENIOR CONSTABLE NELSEN – dated 14/3/2017</b>
<b>CTW35</b>	<b>STATUTORY DECLARATION</b>	<b>Dr EMIL DJAKIC – dated 2/4/2020</b>
<b>CTW36</b>	<b>STATUTORY DECLARATION</b>	<b>Dr EMIL DJAKIC – dated 29/4/2020</b>
<b>CTW37</b>	<b>STATUTORY DECLARATION</b>	<b>CHOI-LING BATTEN – dated 13/8/2020</b>
<b>CTW38</b>	<b>STATUTORY DECLARATION</b>	<b>DR ALEX SUTHERLAND – dated 8/5/2020</b>
<b>CTW39</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SENIOR CONSTABLE HART – dated 17/6/2020</b>

<b>CTW40a-n</b>	<b>000 Calls (inc Transcript)</b>	<b>AMBULANCE TASMANIA</b>
<b>CTW41</b>	<b>PHOTOGRAPHS</b>	<b>DETECTIVE SENIOR CONSTABLE NELSEN</b>
<b>CTW42</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SENIOR CONSTABLE CARTER – dated 14/3/2017</b>
<b>CTW43a-c</b>	<b>INTERVIEW (disc) &amp; AFFIDAVIT</b>	<b>SHANE FAZACKERLEY – dated 20/4/2022</b>
<b>CTW44</b>	<b>AFFIDAVIT</b>	<b>XIAOLING GONG – dated 11/8/2020</b>
<b>CTW45</b>	<b>AFFIDAVIT</b>	<b>CHOI-LING BATTEN – dated 18/2/2020</b>
<b>CTW46a-b</b>	<b>FAMILY STATEMENT &amp; PHOTOGRAPHS</b>	<b>GILLIAN FOWLER</b>



## MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION

<b>LIST OF EXHIBITS</b>
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**Record of investigation into the death of  
Matthew Wayne Winwood aka Juhasz**

No.	TYPE OF EXHIBIT	NAME OF WITNESS
<b><u>FOLDER 1</u></b>		
<b>CMW1</b>	<b>SUBJECT REPORT</b>	<b>SERGEANT R COOKE</b>
<b>CMW2</b>	<b>REPORT OF DEATH</b>	<b>CONSTABLE S LEEK</b>
<b>CMW3</b>	<b>LIFE EXTINGUISHED AFFIDAVIT</b>	<b>DR DAVID BROOK</b>
<b>CMW4</b>	<b>AFFIDAVIT OF IDENTIFICATION</b>	<b>SERGEANT R COOKE</b>
<b>CMW5</b>	<b>MORTUARY AFFIDAVIT</b>	<b>ANTHONY CORDWELL</b>
<b>CMW6</b> <b>CMW6a</b> <b>CMW6b-c</b>	<b>POST MORTEM REPORT AND INTERIM REPORT AUTOPSY PHOTOGRAPHS</b>	<b>DR DONALD RITCHEY</b>
<b>CMW7</b>	<b>TOXICOLOGY REPORT</b>	<b>DR MIRIAM CONNOR</b>
<b>CMW 8</b>	<b>MEDICAL REPORT</b>	<b>AMBULANCE TASMANIA</b>
<b>CMW 9</b>	<b>PHOTOGRAPHS</b>	<b>PHOTOGRAPHS FROM SCENE</b>
<b>CMW10a-i</b>	<b>MEDICAL RECORDS</b>	<b>DARWIN HOSPITAL</b>
<b>CMW11a-b</b>	<b>MEDICAL RECORDS</b>	<b>THS –</b> <ul style="list-style-type: none"> <li>• <b>ROYAL HOBART HOSPITAL</b></li> <li>• <b>LAUNCESTON GENERAL HOSPITAL</b></li> </ul>
<b>CMW12a-ma</b> <b>&amp;</b> <b>Photographs 3-375</b>	<b>MEDICAL RECORDS AND CORRESPONDENCE</b>	<b>DHHS – PHARMACEUTICAL SERVICES BRANCH</b>

<b>CMW13a-s</b>	<b>MEDICAL RECORDS</b>	<b>EASTERN SHORE MEDICAL CENTRE</b>
<b><u>FOLDER 2</u></b>		
<b>CMW14a-c</b>	<b>MEDICAL RECORDS</b>	<b>OATLANDS SURGERY</b>
<b>CMW15</b>	<b>MEDICAL RECORDS</b>	<b>DR LADD'S SURGERY</b>
<b>CMW16</b>	<b>MEDICAL RECORDS</b>	<b>SALVATION ARMY – THE BRIDGE CENTRE</b>
<b>CMW17a-b</b>	<b>MEDICAL RECORDS</b> <ul style="list-style-type: none"> <li>• SOUTH</li> <li>• NORTH</li> </ul>	<b>ADS</b>
<b>CMW18a-b</b>	<b>CLIENT RECORDS</b>	<b>THE HOBART CLINIC</b>
<b>CMW19a-g</b>	<b>CLIENT RECORDS</b> <ul style="list-style-type: none"> <li>• Patient History Report</li> <li>• Patient Summary</li> <li>• Individual Prescribing History</li> <li>• Provider Patient Report</li> <li>• Claims History</li> </ul>	<b>MEDICARE</b>
<b>CMW20a &amp; CMW20b</b>	<b>CLIENT RECORDS &amp; CLIENT RECORDS 29/09/22</b>	<b>DHHS CORRECTIONAL HEALTH</b>
<b>CMW21a-h</b>	<b>PHARMACY RECORDS</b>	<b>NORTH HOBART AMCAL PHARMACY</b>
<b>CMW22a-d</b>	<b>PHARMACY RECORDS</b>	<b>OATLANDS PHARMACY</b>
<b>CMW23a-b</b>	<b>PHARMACY RECORDS</b>	<b>RICHMOND PHARMACY</b>
<b>CMW24a-f</b>	<b>PHARMACY RECORDS</b>	<b>ROKEBY DISCOUNT PHARMACY</b>
<b>CMW25a-c</b>	<b>PHARMACY RECORDS</b>	<b>SHORELINE HOWRAH PHARMACY</b>
<b>CMW26</b>	<b>PHARMACY RECORDS -</b>	<b>TERRY WHITE CHEMMART SORELL</b>
<b>CMW27</b>	<b>CORRESPONDENCE</b>	<b>LETTER FROM DR JACKSON</b>

<b>CMW28a-c</b>	<b>CLIENT RECORDS</b>	<b>DR JACKSON</b>
<b>FOLDER 3</b>		
<b>CMW29</b>	<b>AFFIDAVIT</b>	<b>SNOK – ADRIANA JUHASZ – dated 4/8/2017</b>
<b>CMW30</b>	<b>AFFIDAVIT</b>	<b>SNOK – ADRIANA JUHASZ – dated 23/9/2017</b>
<b>CMW31</b>	<b>AFFIDAVIT</b>	<b>SNOK – ADRIANA JUHASZ – dated 18/3/2018</b>
<b>CMW32a-e</b>	<b>INTERVIEW (DISC AND TRANSCRIPT)</b>	<b>ADRIANA JUHASZ – dated 13/5//2019 (4 x disks)</b>
<b>CMW33</b>	<b>AFFIDAVIT</b>	<b>LORRAINE COULSON – dated 4/8/2017</b>
<b>CMW34</b>	<b>AFFIDAVIT</b>	<b>LORRAINE COULSON – dated 14/2/2018</b>
<b>CMW35</b>	<b>STATUTORY DECLARATION</b>	<b>LORRAINE COULSON – dated 13/5/2019</b>
<b>CMW36</b>	<b>STATUTORY DECLARATION</b>	<b>SHARON PICKEN – dated 14/5/2020</b>
<b>CMW37</b>	<b>STATUTORY DECLARATION</b>	<b>DEBBY RICHARDSON – dated May 2020</b>
<b>CMW38</b>	<b>STATUTORY DECLARATION</b>	<b>MANDY BRAIN - dated 7 May 2020</b>
<b>CMW39</b>	<b>STATUTORY DECLARATION</b>	<b>DANNY WINWOOD – dated 24.3.2020</b>
<b>CMW40</b>	<b>STATUTORY DECLARATION</b>	<b>DALE O'BRIEN – dated 3.6.2019</b>
<b>CMW41</b>	<b>NOT USED</b>	
<b>CMW42</b>	<b>STATUTORY DECLARATION</b>	<b>DR ADRIAN REYNOLDS unsigned</b>
<b>CMW43</b>	<b>STATUTORY DECLARATION</b>	<b>DR MICHAEL LEES – dated 18/12/2019</b>
<b>CMW44</b>	<b>STATUTORY DECLARATION</b>	<b>DR GEORGE WHYTE – dated 2/3/2020</b>
<b>CMW45</b>	<b>STATUTORY DECLARATION</b>	<b>DR GERARD GILL – dated 27/3/2020</b>
<b>CMW46</b>	<b>STATUTORY DECLARATION</b>	<b>NURSE JOSEPHINE MILLS – dated 20/11/2020</b>
<b>CMW47</b>	<b>REPORT</b>	<b>DR JONATHAN BRETT</b>

<b>CMW48</b>	<b>STATUTORY DECLARATION</b>	<b>DANICA IVKOVIC – dated 29/5/2020</b>
<b>CMW49</b>	<b>AFFIDAVIT</b>	<b>BRUCE CONNOR – dated 23/8/2018</b>
<b>CMW50</b>	<b>AFFIDAVIT</b>	<b>SERGEANT COOKE - dated 12.9.2017</b>
<b>CMW51</b>	<b>STATUTORY DECLARATION</b>	<b>SERGEANT COOKE dated 10/1/2020</b>
<b>CMW52</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE LEEK dated 4/8/2017</b>
<b>CMW53</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SERGEANT FOSTER – dated 25/8/2017</b>
<b>CMW54</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE HYLAND – dated 27/8/2017</b>
<b>CMW55</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE LANG – dated 14/11/2020</b>
<b>CMW56</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SEN. CONSTABLE COOPER – dated 8/1/2020</b>
<b>CMW57</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE PARTRIDGE – dated 17/1/2020</b>
<b>CMW58</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE TILLEY – dated 23/12/2019</b>
<b>CMW59</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SEN. CONSTABLE RITSON – dated 10/1/2020</b>
<b>CMW60</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE SINCLAIR – dated 1/6/2020</b>
<b>CMW61a-f</b>	<b>000 CALLS</b>	<b>AMBULANCE TASMANIA &amp; TASMANIA POLICE</b>
<b>CMW62</b>	<b>PRIOR CONVICTIONS – M Winwood</b>	<b>TASMANIA POLICE</b>
<b>CMW63</b>	<b>PRIOR CONVICTIONS – M Winwood</b>	<b>NORTHERN TERRITORY POLICE</b>
<b>CMW64</b>	<b>NOT USED</b>	
<b>CMW65a-d</b>	<b>NOT USED</b>	
<b>CMW66</b>	<b>NOT USED</b>	
<b>CMW67</b>	<b>NOT USED</b>	

<b>CMW68a-b</b>	<b>NOT USED</b>	
<b>CMW69a-b</b>	<b>EMAILS FROM DR REYNOLDS</b>	<b>DR REYNOLDS</b>



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

### LIST OF EXHIBITS

## Record of investigation into the death of Belinda Emma KEMP

No.	TYPE OF EXHIBIT	NAME OF WITNESS
CBK1	Not Used	
CBK2	REPORT OF DEATH	CONST SCOTT
CBK3	LIFE EXTINCT AFFIDAVIT	DR LAUGHLIN
CBK4	AFFIDAVIT OF IDENTIFICATION	CONST SCOTT
CBK5 CBK5a- c	POST MORTEM AFFIDAVIT & PHOTOGRAP HS	DR LAWRENCE
CBK6	TOXICOLOGY REPORT	MIRIAM CONNOR
CBK7a-l	MEDICAL RECORDS	RHH – DISC
CBK8a- m	MEDICAL RECORDS	Dr J MADDEN
CBK9	MEDICAL REPORT	AMBULANCE TAS
CBK10a -r	MEDICAL RECORDS	Dr DAVID JACKSON
CBK11a -q	MEDICAL REPORT & CLIENT RECORDS	DHHS – PHARMECUTICAL SERVICES BRANCH
CBK12a -b	MEDICAL RECORDS	MEDICARE
CBK13	MEDICAL RECORDS	THE HOBART CLINIC
CBK14	STATUTORY DECLARATION	ASHLEIGH REYNOLDS – dated 19/5/2020
CBK15a -j	CLIENT RECORDS	SALVATION ARMY BRIDGE CENTRE
CBK16	PHARMACY RECORDS	BRIGHTON PHARMACY
CBK17	AFFIDAVIT	KENNETH KEMP – SNOK

CBK18	AFFIDAVIT	ALISON BRACKEN – dated 26/7/2018
CBK19	AFFIDAVIT	JASON FAHEY – dated 22/10/2018
CBK20	AFFIDAVIT	KENNETH BRACKEN – dated 2/6/2019
CBK21	AFFIDAVIT	WENDY STEINBERG – dated 16/2/2018
CBK22a -k	TRANSCRIPT OF INTERVIEW & DISC	REBECCA GUERAN
CBK23	AFFIDAVIT	LISA GUERAN – dated 10/7/2018
CBK24	AFFADAVIT	BRETT HERNAN – dated 22/9/2017
CBK25	AFFADAVIT	PARAMEDIC P SCHWARZ – dated 10/9/2018
CBK26	AFFADAVIT	PARAMADIC E CUTHBERT – dated 12/9/2018
CBK27	STATUTORY DECLARATION	DR J MADDEN – dated 6/3/2020
CBK28	AFFIDAVIT	CONSTABLE SCOTT – dated 1/2/2018
CBK29	AFFIDAVIT	SERGEANT FORREST – dated 8/2/2018
CBK30	AFFIDAVIT	CONSTABLE THURLEY – dated 16/11/2017
CBK31	AFFIDAVIT	SNR CONSTABLE TURNBULL – dated 4/12/2017
CBK32	AFFIDAVIT	CONSTABLE BUICK – dated 8/1/2018
CBK33a -b	AFFIDAVIT & PHOTOGRAPHS	CONSTABLE BELLETTE – dated 17/11/2017
CBK34	DRUG CAUTION NOTICE 36551	TASMANIA POLICE
CBK35	TAS HEALTH ORG LETTER	DR SIVASANKARAN
CBK36	Not Used	
CMW28a-c	CLIENT RECORDS	DR JACKSON
<b><u>FOLDER 3</u></b>		
CMW29	AFFIDAVIT	SNOK – ADRIANA JUHASZ – dated 4/8/2017
CMW30	AFFIDAVIT	SNOK – ADRIANA JUHASZ – dated 23/9/2017
CMW31	AFFIDAVIT	SNOK – ADRIANA JUHASZ – dated 18/3/2018
CMW32a-e	INTERVIEW (DISC AND TRANSCRIPT)	ADRIANA JUHASZ – dated 13/5/2019 (4 x disks)
CMW33	AFFIDAVIT	LORRAINE COULSON – dated 4/8/2017

<b>CMW34</b>	<b>AFFIDAVIT</b>	<b>LORRAINE COULSON – dated 14/2/2018</b>
<b>CMW35</b>	<b>STATUTORY DECLARATION</b>	<b>LORRAINE COULSON – dated 13/5/2019</b>
<b>CMW36</b>	<b>STATUTORY DECLARATION</b>	<b>SHARON PICKEN – dated 14/5/2020</b>
<b>CMW37</b>	<b>STATUTORY DECLARATION</b>	<b>DEBBY RICHARDSON – dated May 2020</b>
<b>CMW38</b>	<b>STATUTORY DECLARATION</b>	<b>MANDY BRAIN - dated 7 May 2020</b>
<b>CMW39</b>	<b>STATUTORY DECLARATION</b>	<b>DANNY WINWOOD – dated 24.3.2020</b>
<b>CMW40</b>	<b>STATUTORY DECLARATION</b>	<b>DALE O'BRIEN – dated 3.6.2019</b>
<b>CMW41</b>	<b>NOT USED</b>	
<b>CMW42</b>	<b>STATUTORY DECLARATION</b>	<b>DR ADRIAN REYNOLDS unsigned</b>
<b>CMW43</b>	<b>STATUTORY DECLARATION</b>	<b>DR MICHAEL LEES – dated 18/12/2019</b>
<b>CMW44</b>	<b>STATUTORY DECLARATION</b>	<b>DR GEORGE WHYTE – dated 2/3/2020</b>
<b>CMW45</b>	<b>STATUTORY DECLARATION</b>	<b>DR GERARD GILL – dated 27/3/2020</b>
<b>CMW46</b>	<b>STATUTORY DECLARATION</b>	<b>NURSE JOSEPHINE MILLS – dated 20/11/2020</b>
<b>CMW47</b>	<b>REPORT</b>	<b>DR JONATHAN BRETT</b>
<b>CMW48</b>	<b>STATUTORY DECLARATION</b>	<b>DANICA IVKOVIC – dated 29/5/2020</b>
<b>CMW49</b>	<b>AFFIDAVIT</b>	<b>BRUCE CONNOR – dated 23/8/2018</b>
<b>CMW50</b>	<b>AFFIDAVIT</b>	<b>SERGEANT COOKE - dated 12.9.2017</b>
<b>CMW51</b>	<b>STATUTORY DECLARATION</b>	<b>SERGEANT COOKE dated 10/1/2020</b>
<b>CMW52</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE LEEK dated 4/8/2017</b>
<b>CMW53</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SERGEANT FOSTER – dated 25/8/2017</b>
<b>CMW54</b>	<b>AFFIDAVIT</b>	<b>CONSTABLE HYLAND – dated 27/8/2017</b>
<b>CMW55</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE LANG – dated 14/11/2020</b>
<b>CMW56</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SEN. CONSTABLE COOPER – dated 8/1/2020</b>
<b>CMW57</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE PARTRIDGE – dated 17/1/2020</b>

<b>CMW58</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE TILLEY – dated 23/12/2019</b>
<b>CMW59</b>	<b>STATUTORY DECLARATION</b>	<b>DETECTIVE SEN. CONSTABLE RITSON – dated 10/1/2020</b>
<b>CMW60</b>	<b>STATUTORY DECLARATION</b>	<b>CONSTABLE SINCLAIR – dated 1/6/2020</b>
<b>CMW61a-f</b>	<b>000 CALLS</b>	<b>AMBULANCE TASMANIA &amp; TASMANIA POLICE</b>
<b>CMW62</b>	<b>PRIOR CONVICTIONS – M Winwood</b>	<b>TASMANIA POLICE</b>
<b>CMW63</b>	<b>PRIOR CONVICTIONS – M Winwood</b>	<b>NORTHERN TERRITORY POLICE</b>
<b>CMW64</b>	<b>NOT USED</b>	
<b>CMW65a-d</b>	<b>NOT USED</b>	
<b>CMW66</b>	<b>NOT USED</b>	
<b>CMW67</b>	<b>NOT USED</b>	
<b>CMW68a-b</b>	<b>NOT USED</b>	
<b>CMW69a-b</b>	<b>EMAILS FROM DR REYNOLDS</b>	<b>DR REYNOLDS</b>



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

### LIST OF EXHIBITS

## Record of investigation into the death of Belinda Emma KEMP

No.	TYPE OF EXHIBIT	NAME OF WITNESS
CBK1	Not Used	
CBK2	REPORT OF DEATH	CONST SCOTT
CBK3	LIFE EXTINCT AFFIDAVIT	DR LAUGHLIN
CBK4	AFFIDAVIT OF IDENTIFICATION	CONST SCOTT
CBK5 CBK5a- c	POST MORTEM AFFIDAVIT & PHOTOGRAPHS	DR LAWRENCE
CBK6	TOXICOLOGY REPORT	MIRIAM CONNOR
CBK7a-l	MEDICAL RECORDS	RHH – DISC
CBK8a- m	MEDICAL RECORDS	Dr J MADDEN
CBK9	MEDICAL REPORT	AMBULANCE TAS
CBK10a -r	MEDICAL RECORDS	Dr DAVID JACKSON
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CBK14	STATUTORY DECLARATION	ASHLEIGH REYNOLDS – dated 19/5/2020
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CBK22a -k	TRANSCRIPT OF INTERVIEW & DISC	REBECCA GUERAN
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CBK24	AFFADAVIT	BRETT HERNAN – dated 22/9/2017
CBK25	AFFADAVIT	PARAMEDIC P SCHWARZ – dated 10/9/2018
CBK26	AFFADAVIT	PARAMADIC E CUTHBERT – dated 12/9/2018
CBK27	STATUTORY DECLARATION	DR J MADDEN – dated 6/3/2020
CBK28	AFFIDAVIT	CONSTABLE SCOTT – dated 1/2/2018
CBK29	AFFIDAVIT	SERGEANT FORREST – dated 8/2/2018
CBK30	AFFIDAVIT	CONSTABLE THURLEY – dated 16/11/2017
CBK31	AFFIDAVIT	SNR CONSTABLE TURNBULL – dated 4/12/2017
CBK32	AFFIDAVIT	CONSTABLE BUICK – dated 8/1/2018
CBK33a -b	AFFIDAVIT & PHOTOGRAPHS	CONSTABLE BELLETTE – dated 17/11/2017
CBK34	DRUG CAUTION NOTICE 36551	TASMANIA POLICE
CBK35	TAS HEALTH ORG LETTER	DR SIVASANKARAN
CBK36	Not Used	



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

### LIST OF EXHIBITS

**Record of investigation into the death of  
Nicholas Shane BROWN, Belinda Emma KEMP, Toni Lee WIKI  
and Mathew Wayne WINWOOD (JUHASZ)**

TAB NO.	TYPE OF EXHIBIT	NAME OF WITNESS
<b>GENERAL FOLDER</b>		
<b>FOLDER 1</b>		
<b>G1A</b>	<b>MEDICOLEGAL REPORT (11.05.2018)</b>	<b>DR JONATHON BRETT</b>
<b>G1B</b>	<b>MEDICOLEGAL REPORT (14.07.2022)</b>	<b>DR JONATHON BRETT</b>
<b>G1C</b>	<b>MEDICOLEGAL REPORT (26.5.2023)</b>	<b>DR JONATHAON BRETT</b>
<b>G2</b>	<b>NOT USED</b>	
<b>G3</b>	<b>NOT USED</b>	
<b>G4-1 TO G4-4 G4-8 G4-10 TO G4-20 G4-26 TO G4-33 G4-35 G4-37 TO G4-40 G4-43 G4-47</b>	<b>DOCUMENTATION RELATING TO DR JACKSON</b>	<b>VARIOUS</b>
<b>FOLDER 2</b>		
<b>G5-1 TO G5-4</b>	<b>DOCUMENTATION RELATING TO AZON- JACOMETTI G5-1 RESUME G5-2 SUMMARY OF TEXT MESSAGES G5-3 CODE OF CONDUCT FOR NURSES G5-4 DR JACOMETTI AFFIDAVIT</b>	<b>NIKOLAAS AZON-JACOMETTI</b>
<b>G6</b>	<b>NOT USED</b>	
<b>FOLDER 3</b>		

<b>G7</b>	<b>NOT USED</b>	
<b>G8</b>	<b>NOT USED</b>	
	<b>FOLDER 4</b>	
<b>G9</b>	<b>NOT USED</b>	
<b>G10</b>	<b>NOT USED</b>	
<b>G11</b>	<b>NOT USED</b>	
<b>G12-2</b>	<b>AFFIDAVIT</b>	<b>LF</b>
<b>FOLDER 5</b>		
<b>G13</b>	<b>NOT USED</b>	
<b>G14</b>	<b>NOT USED</b>	
<b>G15-10</b>	<b>EMAILS NUMBERED 1 - 60</b>	<b>ROSALIE YEO</b>
<b>FOLDER 6</b>		
<b>G16-1 TO G16-39 &amp; G16-48</b>	<b>DOCUMENTATION RELATING TO PX</b>	<b>VARIOUS</b>
<b>G17</b>	<b>NOT USED</b>	
<b>FOLDER 7</b>		
<b>G18</b>	<b>NOT USED</b>	
<b>G19</b>	<b>STATUTORY DECLARATION &amp; ANNEXURES</b>	<b>DR GEORGE CERCHEZ – DATED 29/8/2019</b>
<b>G20 &amp; G20a</b>	<b>AFFIDAVIT &amp; ANNEXURES</b>	<b>JERRY HAMPTON – DATED 13/9/2018</b>
<b>G21</b>	<b>NOT USED</b>	
<b>G22</b>	<b>NOT USED</b>	
<b>G23</b>	<b>NOT USED</b>	
<b>G24</b>	<b>NOT USED</b>	
<b>G25</b>	<b>STATUTORY DECLARATION</b>	<b>DR ADRIAN REYNOLDS – UNSIGNED</b>
<b>G26 &amp; G26a</b>	<b>LETTER &amp; ATTACHMENT</b>	<b>PETER BOYLES – DATED 29/8/22 CHIEF PHARMACIST, PHARMACEUTICAL SERVICES BRANCH</b>
<b>G27a-d</b>	<b>PROOF OF EVIDENCE &amp; ANNEXURES</b>	<b>DR NICOLA AIT KHELIFA</b>
<b>G28</b>	<b>TASMANIAN METHADONE POLICY 2000</b>	<b>DEPARTMENT OF HEALTH</b>
<b>G29</b>	<b>TASMANIAN OPIOID</b>	<b>DEPARTMENT OF HEALTH</b>
	<b>PHARMACOTHERPAY PROGRAM – POLICY AND CLINICAL PRACTICE STANDARDS 2012</b>	
<b>G30 &amp; G30a</b>	<b>AFFIDAVIT, ANNEXURES &amp; ABC ARTICLE</b>	<b>PENELOPE CHUGG – DATED 12/9/22</b>

<b>G31</b>	<b>REVIEW OF ALCOHOL AND DRUG TREATMENT FOR TASMANIAN PRISONERS – NOVEMBER 2021</b>	<b>PROFESSOR ADRIAN DUNLOP &amp; DR JILLIAN ROBERTS</b>
<b>G32a-g</b>	<b>STATUTORY DECLARATION G32a - CV G32b - TOPP REVIEW LIST G32c - FILE NOTE G CERCHEZ G32d – PHONE RECORD WITH DR JACKSON G32e – EMAIL G32f – EMAIL G32g - NOTES OF MEETING</b>	<b>ADRIAN REYNOLDS – DATED 12/9/22</b>
<b>FOLDER 8</b>		
<b>G33a-f</b>	<b>G33a – CV G33b – DIAGRAMS G33c – TOXICOLOGY TABLE G33d – STEVEN KARCH ARTICLE G33e – DRUG ABUSE HANDBOOK G33f – BLOOD ANALYSIS – WINWOOD 2015</b>	<b>NEIL MCLACHLAN-TROUP</b>
<b>G34</b>	<b>ANNUAL OVERDOSE REPORT AUGUST 2022</b>	<b>PENINGTON INSTITUTE REPORT</b>
<b>G35</b>	<b>AFFIDAVIT</b>	<b>DETECTIVE SENIOR CONSTABLE TAMI NELSEN – DATED 29.9.22</b>
<b>G36a-f</b>	<b>G36a - AFFIDAVIT G36b – CV G36c – ARTICLE – PREDICTORS OF LONG-TERM BENZODIAZEPINE ABSTINENCE G36d – ARTICLE – EFFECTS OF TELEHEALTH G36e – LETTER 9.8.11 G36f – LETTER 8.5.12</b>	<b>DAVID JACKSON</b>
<b>G37a-m</b>	<b>G37a - CV OF PROF DUFLOU G37b – LETTER OF INSTRUCTION - BROWN G37b – PROF DUFLOU REPORT - BROWN G37d – LETTER OF INSTRUCTION - KEMP G37e – PROF DUFLOU REPORT – KEMP G37f – LETTER OF INSTRUCTION - WIKI G37g – PROF DEFLOU REPORT – WIKI</b>	<b>PROFESSOR JOHAN DUFLOU</b>

	<p><b>G37h – LETTER OF INSTRUCTION - WINWOOD</b></p> <p><b>G37i – PROF DEFLOU REPORT – WINWOOD</b></p> <p><b>G37j – FURTHER LETTER OF INSTRUCTION - WINWOOD</b></p> <p><b>G37k – EMAIL FROM PROF DUFLOU - WINWOOD</b></p> <p><b>G37l – MECHANISMS UNDERLYING TOLERANCE AFTER LONG-TERM BENZODIAZEPINE USE: A FUTURE FOR SUBTYPE-SELECTIVE GABA RECEPTOR MODULATORS</b></p> <p><b>G37m – BENZODIAZEPINES IN EPILEPSY: PHARMACOLOGY AND PHARMACOKINETICS</b></p>	
<b>G38a-b</b>	<b>AFFIDAVIT – BROWN &amp; KEMP</b>	<b>DR LAWRENCE – DATED 5/5/23</b>
<b>G38c-d</b>	<b>AFFIDAVIT – WIKI &amp; WINWOOD</b>	<b>DR RITCHEY – DATED 5/4/23</b>
<b>G39</b>	<b>AFFIDAVIT</b>	<b>PETER BOYLES – DATED 26/5/23 CHIEF PHARMACIST, PHARMACEUTICAL SERVICES BRANCH</b>
<b>G40</b>	<b>MEDICARE RECORDS- MATHEW JUHASZ (Winwood)</b>	<b>MEDICARE</b>
<b>G41</b>	<b>MEDICARE RECORDS – KEMP, BROWN WIKI, STEER, BUCK &amp; PX</b>	<b>MEDICARE</b>



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION

### ANNEXURE B

#### Inquest Witness List

	<b>Witness</b>	<b>Title</b>	<b>Transcript order</b>
1	Melissa McCoy	Partner of Nicholas Brown	63
2	Dr Donald Ritchey	Forensic Pathologist, Statewide Forensic Medical Services Tasmania	81
3	Michelle Gordon	Partner of Melissa McCoy's Father	160
4	Rachel Perigo (formerly Keegan)	Senior Constable, Tasmania Police	176
5	Anton Bartulovic	Intensive Care Flight Paramedic, Ambulance Tasmania	198
6	William Brown	Father of Nicholas Brown	213
7	Dr Christopher Wake	Head of Correctional Primary Health Services - Division of Statewide Mental Health Services in Tasmania	234
8	Olivia Gillie	Pharmacist	259
9	Michael Nash	Pharmacist	292
10	Paul Hyland	Senior Constable, Tasmania Police	358
11	Carey Burns	Paramedic, Tasmania Ambulance Service	386
12	Tami Nelsen	Detective Senior Constable, Southern Drug Investigation Services, Tasmania Police	401
13	Jarrold Tuffin	Former partner of Toni Wiki	440
14	Shane Fazackerley	Associate of Toni Wiki	461
15	Gillian Fowler	Mother of Toni Wiki	478
16	Ella Mackay (formerly Cuthbert)	Paramedic, Tasmania Ambulance Service	511
17	Ian Bellette	Constable, Crime Scene Examiner Forensic Services, Tasmania Police	520
18	Alison Bracken	Housemate of Belinda Kemp	543
19	Kenneth Bracken	Father of Alison Bracken	576
20	Dr Christopher Lawrence	Forensic Pathologist, Director of Statewide Forensic Medical Services, Tasmania.	583
21	Dr Anna McKinlay	General Practitioner, Aboriginal Health Service	632
22	Carol Brown	Aunt of Nicholas Brown	658

23	Mary Cook	Pharmacist - Retired	707
24	Bruce Conner	Intensive Care Paramedic Ambulance Tasmania	766
25	Lorraine Coulson	Friend and neighbour of Matthew Winwood	778
26	Dr Michael Lees	General Practitioner - Oatlands	813
27	Neil McLachlan-Troup	Analyst, Forensic Science Service Tasmania, Chemistry Department within Toxicology	876
28	Dr Jonathan Brett	Clinical Director of the Opioid Replacement Therapy Unit, St Vincents Hospital.	984
29	Conan Zeigler	Pharmacist	1125
30	Dr Nicole Ait Khelifa	Southern Staff Specialist, Alcohol and Drug Services Tasmania	1173
31	Stephen Ives	Pharmacist	1247
32	Wendy Steinberg	Pharmacist	1263
33	Jeremy Hampton	Pharmacist	1316
34	Peter Boyles	Chief Pharmacist, PSB, Department of Health	1450
35	PX	ORT patient of Dr Jackson	1553
36	Debby Richardson	Sister of Matthew Winwood	1595
37	Sharon Picken	Sister of Matthew Winwood	1616
38	Dr Adrian Reynolds	Clinical Director, Alcohol and Drug Services, Statewide Specialist Services, DHHS	1679
39	Penelope Chugg	Salvation Army Alcohol and Drugs Program	1765
40	Martin Quigley	Former partner of Toni Wiki	1837
41	Professor Johan Duflou	Forensic Pathologist	1915
42	Nikolaas Azon-Jacometti	Registered Nurse	2143
43	Dr George Cerchez	General Practitioner	2298
44	David Jackson	Former Registered Medical Practitioner	2352