



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

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

I, Madeleine Wilson, Coroner, having investigated the death of HK

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

- a) The identity of the deceased is HK, date of birth 13 December 1991.
- b) HK was the eldest of three children born to AE and LR. She attended Perth Primary School, Kings Meadows High School and Launceston College. Following College, HK commenced an apprenticeship with a florist. She worked in communications and later in administration, working primarily in medical centres.

HK met her partner, UT, in 2014 through mutual friends and a shared interest in speedway. They bought their home at Frederick Street, Perth in 2015 and were the parents of PC, born in 2019, and JL, born in 2024. UT described HK as an “awesome” mum whose children “were her whole world”.

HK had no significant health issues. She suffered a fractured ankle in 2022, experienced hyperemesis gravidarum in June 2023 during her second pregnancy, and had consulted her general practitioner about weight loss. She had tried Duromine (an appetite suppressant) but had reportedly ceased it in 2022. She consulted her general practitioner (GP) again in August 2024 about weight loss and stated that she had briefly restarted Duromine in 2024, following the birth of her second child, but had found it ineffective. At that time, her GP recorded that her weight was 110 kilograms and her Body Mass Index (BMI) was 40.4, placing her in the obese class

III range¹. She discussed the option of starting Ozempic and resolved to trial it for two to three months and then review. HK was prescribed Ozempic at 1mg dose once weekly in August 2024². She received a repeat prescription for Ozempic at the same dose in December 2024.

For several weeks before her death, HK had had an upset stomach, diarrhoea and vomiting. Although prone to these symptoms after eating 'junk food'³ the symptoms had lasted longer than usual⁴. An appointment was made to consult her general practitioner on 27 December 2024, but at some point, HK cancelled the appointment.

In the afternoon of Thursday, 26 December 2024, HK dropped both her children at her parents' house for the night and attended to errands, in preparation for a family trip in the caravan to Bridport the following day. She and UT spent the evening together at the speedway at Carrick. On the way home, HK drove to McDonald's and purchased a cheeseburger. They arrived home shortly before midnight.

On Friday, 27 December 2024, UT left for work at 5.45am as usual, at that time, HK was still in bed sleeping. They exchanged text messages between 8:23am-8:46am. HK also communicated with her parents about how the children had slept the previous night and indicated that she was intending to go to the supermarket, and then she would come and collect the children.

At approximately 9:23am HK drove her Honda CRV station wagon, registered number L88VM, in a westerly direction along Frederick Street in Perth, Tasmania, towards the intersection with Main Road. Prior to reaching the intersection, the Honda deviated from its correct lane of travel and crossed onto the incorrect side of the road. As she approached the intersection, HK's vehicle remained within the oncoming eastbound traffic lane and proceeded to the right of the traffic islands situated at the

¹ Department of Health, Disability and Ageing: <https://www.health.gov.au>> overweight-and-obesity

² In Australia, the recommended starting dose for Ozempic is .25mg for 4 weeks and then slowly increase. <https://www.ozempic.com> A dosage of 1mg may have accounted for HK feeling unwell and nauseous.

³ Affidavit of UT

⁴ The most common side effects of Ozempic may include nausea, diarrhea, stomach pain, constipation and/or vomiting. The most commonly reported side effects are related to the stomach and digestion. Combining Ozempic with greasy food is not recommended: <https://www.ozempic.com>

intersection. HK proceeded through the intersection in conditions consistent with hard acceleration, without giving way to the traffic.

After crossing Main Road, HK's car mounted the kerb adjacent to the Exclusive Cars premises on the corner of Frederick Street and Main Road and proceeded onto the adjacent grass nature strip, where it ran over a give way sign and travelled west along the nature strip, then entered the rear car park of Exclusive Cars, where it collided with the front ends of two stationary vehicles, then hit the brick wall of the Exclusive Cars workshop.

At the scene, bystanders extricated HK, who was unconscious, from the vehicle and commenced cardiopulmonary resuscitation (CPR). Upon arrival, paramedics continued CPR for a further 30 minutes. Sadly, HK could not be revived, and she was pronounced deceased at the scene.

HK's death was fully investigated by Tasmania Police.

Northern Crash Investigation Services analysts were unable to determine the speed of the vehicle, but the scene evidence was consistent with the vehicle travelling at speed from the time it crossed Main Road until its final collision with the building. There was no evidence of any emergency braking, skidding or evasive action over the entire travelled area to final impact.

HK's vehicle was inspected by a Transport Safety and Inspection Officer who determined that the vehicle was in a compliant condition prior to the crash.

The police investigation revealed that at the time of the collision, the weather was clear, and the road was dry. There were no visible defects to the surface of the roadway which could have caused or contributed to the collision. Mobile phone use was eliminated as a possible factor in the collision. There was evidence that HK was wearing her seatbelt at the time of the collision.

Routine toxicology testing showed the presence of therapeutic levels of paracetamol and ibuprofen. Loperamide, used for the treatment of diarrhoea, was also detected. The presence of those drugs suggests that HK may have been feeling unwell on the day of her death. However, the fact that she had cancelled her appointment with her general practitioner may suggest that the medication had had the desired effect.

Alcohol, drugs of common abuse and carboxyhaemoglobin were not detected in the toxicology testing. Ozempic is a non-target analyte in the routine screening procedure, therefore its presence or absence could not be confirmed.

A complete autopsy with ancillary investigations was undertaken by a Forensic Pathologist, Dr Rebecca Irvine. Dr Irvine reported that HK had no significant medical history, no significant injury on CT scans or postmortem examination, no intoxicating substances on toxicological examination, no identifiable metabolic derangement, she had tested negative to SARS-CoV-2, and there were no significant demonstrable medical conditions on postmortem examination.

Specifically, she noted that there was no evidence of anaphylaxis or allergic reaction and that *commotio cordis* (disruption of cardiac rhythm due to a blow to the chest) was unlikely, as there was evidence that HK had been wearing a seatbelt.

With reference to Ozempic, she stated:

“Ozempic does not appear to increase the risk of atrial and ventricular arrhythmias and sudden cardiac death, seizures or hypoglycaemia (unless combined with other hypoglycaemic medication). This medication is, however, relatively new, and rare but serious adverse events may not have been fully elucidated.”

Dr Irvine also stated:

*“Possible mechanisms of death which cannot be demonstrated at autopsy include seizure, coronary artery spasm, patchy myocarditis and cardiac conduction abnormalities. Of concern to her family, the deceased may have had a **genetic channelopathy**⁵ (innate condition that may alter cardiomyocyte ion channel function in a manner that predisposes to abnormal cardiac rhythms and sudden cardiac death). It is recommended that first degree natural relatives of the deceased, especially siblings and children, discuss this possibility with their GPs so that this concern can be investigated if appropriate. The deceased’s DNA has been stored at the RHH laboratory (specimen J002613) and can be made available to appropriate specialist physicians...”*

⁵ Emphasis added.

Dr Anthony Bell, was asked to review the medical records relating to any medication prescribed to HK and the toxicology results, and to provide an opinion as to the side effects of those.

He reported that a recent review of Semaglutide in the New England Journal of Medicine did not report any incidence of increased cardiovascular disease, in fact the rate decreases in patients treated for obesity and not diabetes.

He also reported that Loperamide (used to control acute and chronic diarrhoea) was known to cause QT interval prolongation and torsades de pointes. He stated:

“QT prolongation is a heart electrical conduction delay- seen on an electrocardiogram (ECG) as a long interval between the Q and T waves- where the heart takes too long to recharge between beats. This condition increases the risk of dangerous, rapid heart rhythms (arrhythmias) like torsades de pointes. Key causes include genetic mutations (congenital), electrolyte imbalances and various medications. Torsades de pointes is a rare, life-threatening form of polymorphic ventricular tachycardia (fast heart rhythm) characterized by twisting of QRS complexes on an electrocardiogram (ECG). It arises from a prolonged QT interval, often caused by medications, electrolyte imbalances (low magnesium/potassium), or congenital conditions. Symptoms include dizziness, palpitations, fainting and cardiac arrest.”

Dr Bell warned that patients with suspected QT prolongation require careful evaluation of the QT interval (being the most useful diagnostic and prognostic parameter) on serial ECGs. He noted that there were no ECGs in HK’s medical records, but that ECG may be diagnostic or suggestive of cardiac conditions that can cause cardiac arrest, including channelopathies.⁶ Dr Bell also recommended testing by ECG for QT prolongation in first degree relatives as an inexpensive screening test. He considered that;

⁶ Dr Bell’s report identifies that “Cardiac channelopathies are inherited genetic disorders of cardiomyocyte ion channels- sodium, potassium or calcium that disrupt electrical signalling without affecting heart structure.” He identifies three genes that “account for approximately 80-90% of congenital Long QT syndrome (LQTS) cases”.

“Worth considering in this case is QT prolongation channelopathies. The patient was thought to be unwell on the day of the event. The loperamide may have been sufficient to cause sudden cardiac death”.

I find that illicit drugs, alcohol, mobile phone use, the roadworthiness of the vehicle, environmental factors, such as the condition of the road and the weather conditions at the time, the involvement of a third party and suicide played no part in HK’s death.

I am satisfied on the balance of probabilities that HK’s manner of death was natural and that she suffered a medical event while driving.

However, the investigation into the death of HK has not disclosed a clear medical cause of death.

It is possible that HK had a genetic channelopathy, such as Long QT Syndrome (LQTS) and that taking loperamide for diarrhoea (which may or may not have been a side effect of taking Ozempic) caused QT interval prolongation, leading to cardiac arrest, however I am not satisfied to the requisite standard, that the cause of HK’s death is able to be determined.

c) HK’s cause of death is unable to be determined.

d) HK died on 27 December 2024 at Perth, Tasmania.

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

- The Police Report of Death for the Coroner;
- Hospital Death Report to the Coroner;
- Affidavits confirming identity;
- Affidavit of Alan Fitzpatrick
- Affidavit of UT;
- Affidavit of Constable Alison Mackay;
- Affidavit of Senior Constable Joseph Cook;
- Affidavit of Sergeant Scott McKinnell;
- Affidavit of Senior Constable Michael Rybka;
- Mobile phone records;
- Medical records;
- Tasmania Police records;
- CCTV footage;

- Affidavit of forensic scientist Neil McLachlan-Troup;
- Report of forensic pathologist Dr Rebecca Irvine regarding cause of death; and
- Report of Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant.

Comments and Recommendations

Based on the opinions expressed in Dr Irvine's Forensic Pathology Report and Dr Bell's Medical Report, I urge all first-degree relatives of HK to undergo testing for genetic channelopathy, in particular QT interval prolongation channelopathy.

I extend my appreciation to investigating officer Senior Constable Michael Rybka for his investigation and report.

The circumstances of death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

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

Dated: 26 May 2026 at Hobart, in the State of Tasmania.

Madeleine Wilson
Coroner