MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

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

I, Olivia McTaggart, Coroner, having investigated the death of UN

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

a) The identity of the deceased is UN, date of birth 20 August 1979.

b) UN was 43 years of age, in a defacto relationship and had six children from previous relationships. UN was born in Bankstown, New South Wales. Following school, UN completed an apprentiship in bricklaying and, once qualified, continued to work as a bricklayer in Sydney. In 2004 UN moved to South Hobart in Tasmania and commenced employment as a plasterer. He developed chronic back pain, depression and alcohol abuse. He ceased work in about 2018. UN had a history of intravenous drug use. He also had a lengthy criminal history, including for family violence offending.

In the period before his death he used methamphetamine (ice) recreationally about once a week, smoked approximately 15-20 cigarettes a day and consumed alcohol daily. He relied heavily on prescription medication, primarily tramadol, pregabalin, and temazepam. He used excessive quantities of these medications and would source additional supplies illicitly.

On 26 March 2023, both UN and his partner, TR, had admitted themselves into the Royal Hobart Hospital (RHH) following infections from self-administering synthetic ice. While in hospital, they both contracted Covid-19. UN became increasingly unwell. However, TR recovered and was discharged from hospital on 3 April 2023.

On the morning of 3 April 2023, while TR was still in hospital, UN had a telephone appointment with his general practitioner, who prescribed him his regular pregabalin and temazepam. UN did not disclose to his doctor that he was in the hospital at the time. UN then collected his prescription temazepam (but not the pregabilin) from a pharmacy nearby and returned to the hospital.

The following day, 4 April 2023, TR took UN to his residence in South Hobart, allegedly to collect some clothing. UN was still an inpatient at the time. Prior to arriving at his home, they stopped into a pharmacy to collect TR's personal prescription and to fill UN's prescription for pregabalin that had been prescribed the previous day. While at UN's residence, TR collected some of her belongings. In her affidavit she said that she then decided to give the bathroom a "quick clean". She said that when she returned to UN after a period of approximately 10-15 minutes, she found UN "*slumped forward with his head in between a tv cabinet and another shelf*".

TR phoned 000. Upon the operator's instructions she performed CPR upon UN. TR said in her affidavit that she then became aware UN had consumed the methadone she had collected from the pharmacy earlier that day. This is contrary to her account given to the hospital in the Emergency Department Letter where it is recorded "*then she took him shopping today and at some point gave him 40mg of HER methadone*". She was also aware UN had taken pregabalin and temazepam that day in substantial but unknown quantities. I find that TR knowingly supplied UN with a quantity of her methadone, knowing that he would inject it.

Ambulance Tasmania paramedics arrived at the residence and continued performing CPR. UN was unresponsive, and had no palpable pulse. They were able to recover a pulse and transported him back to the RHH. On 6 April 2023 it was evident that UN, having been without oxygen for an extended period, was considered brain dead. On 9 April 2023, UN was formally declared deceased.

Toxicology testing reports from hospital blood samples indicate that UN had numerous substances in his system at the time of his cardiac arrest at home. These included methadone, one or more benzodiazepines (including temazepam), oxycodone, pregabalin and tramadol.

c) UN's cause of death was hypoxic brain injury caused by a cardiac arrest that occurred because of unintentional drug poisoning due to a dangerous combination of central nervous system depressant substances. I find upon the evidence that UN voluntarily ingested excessive quantities of his prescribed medication and illicit substances. In addition to the excessive consumption of his own prescription medication, UN also injected the methadone that was prescribed to his partner TR, which substantially contributed to his death.

d) UN died on 9 April 2023 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity and life extinct;
- Opinion of the forensic pathologist who performed the autopsy;
- Toxicology report of Forensic Science Services Tasmania;
- Ambulance Tasmania records;
- General practitioner records for UN;
- Tasmanian Health Service records for UN;
- General Practitioner records for TR;
- Pharmaceutical Services Branch report the Chief Pharmacist;
- Affidavit of TR, partner of UN;
- Affidavit of ER, father of deceased;
- Affidavit of Michael Vasquez, paramedic;
- Affidavit of five attending and investigating police officers together with photos and body worn camera footage; and
- Tasmania Police family violence reports and convictions for UN;
- Interview by investigating officer with Dr Franz-Joseph Itterman; and
- AHPRA records.

Comments and Recommendations

UN had a long term addiction to his prescribed medication and illicit drugs.

In the lead up to his death, he sought and was given additional supplies of medication from his general practitioners at a time when he should already have had ample quantities if he had taken them as prescribed. These supplies allowed UN to stockpile and also to take excessive quantities.

In his comprehensive report for the investigation, the Chief Pharmacist, responsible for the operation of the Pharmaceutical Services Branch (Department of Health), noted that UN had been declared drug dependent and drug seeking and had been diagnosed with opioid use disorder as far back as 2006-2007.

A significant focus of this investigation was the appropriateness of the prescribing of medication to UN by his general practitioners, and in particular Dr Franz-Joseph Itterman, in the months leading to his death. The Coronial Nurse, Mr Kevin Egan, conducted an independent analysis of the prescribing records for UN for the four months prior to his death. This is summarised below.

On 13 December 2022, Dr Itterman prescribed UN temazepam (25 days supply) and pregabalin (18 days supply). Only nine days later, on 22 December 2022, a different doctor in the practice prescribed him another 18 days supply of pregabalin. Seven days following that, on 29 December 2022, another doctor prescribed a further 25 days supply of temazepam and 18 days supply pregabalin prior to going into custody on 11 January 2023.

On 22 March 2023, the day following UN's release from custody, Dr Itterman prescribed him his usual quantities of temazepam (25 days supply), pregabalin (18 days supply) and tramadol (30 days supply). As discussed above, Dr Itterman's prescription for the pregabalin was filled by UN on 3 April 2023 when he was still a hospital inpatient.

On that same day, 3 April, in a telehealth consultation with Dr Itterman from hospital, UN was supplied unnecessarily with further prescriptions of pregabalin (18 days supply) and temazepam (25 days supply). Despite the supplies from previous prescriptions, UN then filled the prescription for pregabalin the following day, 4 April 2023, at a different pharmacy.

The Chief Pharmacist remarked in his report that the provision of multiple prescriptions to UN prior to his death allowed him to attend different pharmacies and obtain early supply of these substances without the pharmacists being aware of the supplies already dispensed.

The Chief Pharmacist discussed in his report the issues surrounding the last prescriptions of temazepam, pregabalin and tramadol to UN. He stated that the prescribing of these high-risk affect-modulating substances, combined with UN's documented history of illicit substance use, including intravenous drug use, placed him at very high risk of medication misadventure and death. I accept this opinion.

The Chief Pharmacist further reported:

> *"The death of UN highlights the necessity of health practitioners treating patients with opioid use disorder to continually consider the chronic relapsing unremitting nature of this condition and the need to conduct frequent risk assessments including but not limited to:*
>
> - *unannounced urine drug screens*
> - *checking the signs of injecting drug use, and*
> - *undertaking and documenting the risk-benefit assessments*
>
> *to ensure the judicious use of these high-risk substances".*

There is no evidence that, during the relevant period, any of the three general practitioners with whom he consulted put in place any, or any sufficient, risk mitigation strategies. There was ample evidence in the practice records over many years that UN was prone to drug misuse.

I have decided in this investigation to focus upon the final episodes of prescribing by Dr Itterman as they bear connection with UN's death. However, I do note that whilst Dr Itterman saw UN in the several months prior to his death, he was not UN's regular general practitioner for the many years that he had been treated at that practice. It may well be that, historically, there was a lack of appropriate restrictions on prescribing medication to UN. I make no further comment on this point.

Certainly, in the examination of the general practitioner records in the months before his death, there is no evidence that a staged supply of medication was considered. Staged supply is a clinical management tool involving a structured pharmacist service, where the supply of a substance to a patient is in instalments in order to mitigate intentional overuse, stockpiling or diversion of prescribed high risk medications.

In the final two consultations of 22 March 2023 and 3 April 2023, Dr Itterman should have been aware of the excess quantities he was prescribing UN and the likelihood of misuse. At the very least, he should not have issued him with prescriptions on 3 April 2023 as his next prescriptions were not due. I find that a significant cause of UN's death was his ability to access large quantities of pregabalin and temazepam on that date because of inappropriate prescribing.

There is no evidence that Dr Itterman was aware, in the telephone consultation on 3 April 2023, that UN was a hospital inpatient due to complications of an extended period of intravenous drug overdose. I also accept that Dr Itterman may not have had any

specific reason to suspect that UN would additionally inject TR's methadone, a high-risk substance in itself. However, his history of drug dependency and abuse meant that it was foreseeable that he would use illicit substances in conjunction with his prescription medication.

An opportunity, both by correspondence and by contact from an investigating officer, has been provided in this investigation for Dr Itterman to make comment upon the matters raised above. Dr Itterman, now retired, chose not to provide any further response. A search of AHPRA[1] records revealed that Dr Itterman had not been the subject of any prior complaint or disciplinary action in Australia regarding prescribing excessive quantities of medication.

I **comment** that it is particularly important that general practitioners, in conjunction with pharmacies, take all appropriate risk mitigation strategies when prescribing high-risk medications to patients who are drug dependent or known to misuse the medication.

I also **commen**t that, with the recent introduction of TasScript[2], the dispensing to UN of pregabalin on consecutive days at different pharmacies would likely not have occurred. Under TasScript, pregabalin is a monitored Schedule 4 medication. Therefore the second dispensing pharamacist would have received a notification of the previous day's dispensing of the same medication and likely not filled the prescription. The same real-time warning system regarding concerning dispensing events applies to numerous other high-risk drugs, including benzodiazepines such as temazepam.

I extend my appreciation to investigating officer Constable Robert Cassidy for his helpful investigation and report.

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

Dated: 7 January 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner

[1] Australian Health Practitioner Regulation Agency.

[2] TasScript 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.