



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 ZA

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

- a) The identity of the deceased is ZA, date of birth 14 August 1972.
- b) ZA was 51 years of age, was unemployed and lived in Legerwood by herself. She has three children. Her husband died of cancer in February 2023, six months before her death. ZA had an extensive medical history, including chronic pain and depression. She had made numerous suicide attempts, likely associated with physical and emotional abuse by her husband. She had been declared drug dependent under the *Poisons Act 1971* and had a long history of requesting from her general practitioner early supplies of medicines and taking excessive quantities of benzodiazepines. For many years, she had been prescribed by her general practitioners in Scottsdale a high-risk combination of sedative and narcotic medication for her conditions. At times, ZA also engaged in selling and swapping her medications with others. Additionally, she abused alcohol and smoked cigarettes.

Her general practitioners over the years were aware of her drug dependence and longstanding propensity to misuse medications. From October 2021, her new treating general practitioner at the same practice, Dr Julie Hadzic, made concerted attempts to reduce ZA's prescribed benzodiazepines and opioids upon recommendations of specialists. Dr Hadzic also attempted to organise appropriate referrals to a pain specialist and psychologists. ZA was always resistant to such attempts and made

excuses to delay medication reduction. At the time of her death, ZA was required to collect her medications from the pharmacy on a weekly basis.

In the early afternoon of 16 September 2023, ZA was at home and commenced consuming beer. Her son, EP, who was with her that evening and overnight, estimated that she likely consumed in excess of 15 full-strength stubbies of beer before going to sleep. The following morning, ZA came out of the house to say goodbye to EP and her granddaughter as they left. She told EP that she was going to have a lie down because she was still feeling tired. At 10.30am she spoke to her mother on the phone, slurring her words. Her mother asked if she had been drinking and she said she had not but was going to have a lie down. Following that time, EP, her son tried to contact her without success. He then called police and ambulance to her house, as well as asking a family friend, TU, to check on her. TU, upon attending her house, found her unresponsive and face down on the floor of the toilet with her head out the door. She was wearing her nightclothes. It was clear that she was deceased. Ambulance Tasmania personnel confirmed that she was deceased, and police officers attended the scene to commence an investigation. The attending officers did not observe any specific evidence, such as notes, that ZA had deliberately ended her own life. There was also nothing at the scene to indicate that her death was suspicious or that any other person was involved. A variety of prescription medications and empty beer bottles were found in her bedroom and around the house.

- c) A full autopsy was conducted by forensic pathologist, Dr Donald Ritchey. Dr Ritchey did not identify any anatomical cause of death, although toxicology testing revealed the presence of numerous strong central nervous system depressant medications in ZA's blood. This included oxycodone, morphine, codeine, diazepam, quetiapine, topiramate, venlafaxine, valproic acid and gabapentin. These medications had been previously or currently prescribed to ZA. Dr Ritchey formed the opinion that, in combination, these drugs caused central nervous system depression and then death by a mechanism of respiratory compromise. Based upon Dr Ritchey's opinion and the toxicology analysis, I find that ZA died unintentionally of prescription drug poisoning. It is not possible upon the scene evidence or toxicological analysis to identify whether ZA ingested her prescription medications in a quantity greater than prescribed just before her death, whether she ingested additional medications

hoarded from past prescriptions or whether she ingested her medications as prescribed. On any scenario, her unintentional poisoning death was a foreseeable consequence of the quantity and combination of ingested medications.

d) ZA died on 17 September 2023 at Legerwood, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity and life extinct;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology report of Forensic Science Service Tasmania;
- Report of Pharmaceutical Services Branch;
- Medical records;
- Affidavit of EP and CK, sons of ZA;
- Affidavit of HO, mother of ZA;
- Affidavit of TU, who discovered ZA deceased;
- Police scene photographs and body worn camera footage;
- Tasmania Police records;
- Affidavit of Dr Julie Hadzic, ZA's general practitioner; and
- Review of treatment and prescribing by Dr Anthony Bell. MD FRACP FCICM, Coronial Medical Consultant.

Comments and Recommendations

Over a very long period of time, her successive general practitioners in Scottsdale prescribed ZA numerous central nervous system depressant medications, including opioids and benzodiazepines. In a person prone to misuse, there is a particularly heightened risk that the combination of the medications will cause unintentional death by a mechanism of central nervous system depression and respiratory compromise. Unfortunately, in the case of ZA, that eventuated.

Upon reviewing the case, the coronial medical consultant, Dr Anthony Bell, noted that in the 20 years up until 2019, ZA was treated and managed by one general practitioner (now retired) at the same practice. Dr Bell commented that that practitioner made minimal effort to reduce ZA's use of opiates analgesia and benzodiazepines. However, he further commented that this may have been reflective of past medical training when the issues of long-term use of benzodiazepines were

less known and long-term use was a more acceptable practice. He stated that since the end of 2019, the focus of ZA's general practitioners was aimed at reducing her drug doses and health maintenance.

It is very clear from the evidence that from 2019 onwards, it was too difficult for her new general practitioners to implement the optimal management strategies, even though the weaning of dangerous medications was regularly discussed and attempts were made to refer ZA to psychological and other non-pharmacological sources of assistance.

Dr Hadzic said in her affidavit for the investigation:

“ZA would agree that better coping mechanisms and better pain management solutions other than medications were needed for her, however each visit when we discussed a reduction in the medications she would have a new event, or crisis to navigate which made the reduction difficult. There were times that regardless of the event, I would reduce the medication anyway, however it did not occur at the rate that ZA and I had agreed at the outset of her medication reduction plan and throughout her treatment. Some of ZA's reasons were real, such as the terminal illness and subsequent death of EW, however some I suspect were not real”.

Dr Hadzic went on to state that shortly before ZA's death, she handed ZA's care to another doctor at the Medical Centre partly because she was struggling to reduce ZA's medications to her satisfaction and considered that a fresh doctor could provide a new approach.

I accept the opinion of Dr Bell that since 2019 the general practitioners treating ZA, including Dr Hadzic, provided reasonable treatment by attempting to have her comply with a holistic management plan and reduction of her medications to safer levels. However, the insurmountable barriers to success included her long history of being liberally prescribed opiates and benzodiazepines, her misuse and dependence upon the medication, her poor mental health, her chronic pain and her refusal to accept appropriate specialist and other health referrals. I therefore make no criticism of the treatment provided since that time and until her death.

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

I extend my appreciation to investigating officer Constable Luke Hooper for his investigation and report.

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

Dated: 23 March 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart

Coroner