IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005266

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	DM[1]
Date of birth:	2 May 1979
Date of death:	Between 10 and 11 September 2022
Cause of death:	1(a) Combined drug toxicity (tapentadol, sertraline, gabapentin, periciazine, carbamazepine, diazepam, zopiclone, promethazine)
Place of death:	1/58 Elaine Avenue, Alfredton, Victoria

[1] This Finding has been de-identified by order of Coroner David Ryan which includes an order to replace the names of the deceased and her family with pseudonyms for the purposes of publication.

INTRODUCTION

1. On 11 September 2022, DM was 43 years old when she was located deceased in her home. At the time of her death, DM lived alone on Alfredton. She is survived by her husband, AM, and her children, FM and GM.

BACKGROUND

2. DM's medical history included asthma, schizoaffective disorder, borderline personality disorder, insomnia, post-traumatic stress disorder, chronic pain, anxiety and depression. She also had a long history of suicidal ideation and self-harm. DM was prescribed multiple medications, including tapentadol, sertraline, gabapentin, periciazine, carbamazepine, diazepam, zopiclone, and promethazine.

3. Since she was 16 years old, DM had been treated for her mental illness by Consultant Psychiatrist Dr John Cocks. She was initially treated with clozapine and also responded well to electroconvulsive therapy (**ECT**). Over the years, DM had multiple admissions to the Albert Road Clinic relating to her mood disorders. Dr Cocks reported that he had a good working relationship with DM but had not seen her for some time before her death. He recalled that she was a very likeable and engaging person when well.

4. On 27 October 2016, DM was assaulted when she attended a martial arts tournament with her daughter. After this incident, DM's mental health deteriorated and in the years that followed, she had multiple presentations to hospital, often in the context of medication overdose.

5. In around 2020, AM and DM separated and FM and GM lived with their father in Sulky.

6. On 4 September 2022, DM contacted emergency services and was transported to the Ballarat Hospital after overdosing on medication, including tapentadol, zopiclone, sertraline and gabapentin. She was transferred later that day to the Intensive Care Unit at Sunshine Hospital. The following day, she was placed on an Assessment Order under the *Mental Health Act 2014* after attempting to strangle herself with the cord from her call bell.

7. On 6 September 2022, DM was reviewed by mental health clinicians at Sunshine Hospital. They considered that she presented a chronic risk of impulsive self-harm but were not satisfied that any acute risk would be mitigated by an involuntary inpatient admission. They noted that DM was remorseful for her actions, denied any current suicidal ideations or plans, did not exhibit delusional content or overt perceptual disturbances, and demonstrated appropriate insight. After consultation with DM's father, KL, she was offered a voluntary admission, which she declined. The Assessment Order was revoked and DM was advised to follow up with Dr Cocks and her General Practitioner (**GP**).

8. DM was discharged on 6 September 2022 at 3.30pm. Mr KL picked his daughter up from the Wendouree Railway Station and drove her home.

9. On 7 September 2022, DM attended Dr Sam Shalaby at the Ballarat Group Practice presenting with chronic pain and obtained further scripts for her usual medications. She stated that she had run out as Dr Cocks had been on leave. Later that day, Dr Shalaby was contacted by the pharmacy in Delacombe, who advised that the previous week, DM obtained the same medications from them that were prescribed that day. Dr Shalaby requested the pharmacist to cancel the prescriptions and requested that DM make a follow-up appointment.

10. On 8 September 2022, DM attended Dr Miguel Dajao at the Ballarat Group Practice. It was agreed at the practice that he would become her regular treating GP, and he had consulted with Dr Shalaby about her recent attendance. DM told Dr Dajao that she had lost some of her medications by leaving them on the train. He subsequently prescribed her with a week's supply of tapentadol, zopiclone and diazepam. DM did not report any suicidal ideation.

THE CORONIAL INVESTIGATION

11. DM's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

13. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

14. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of DM's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Further evidence was obtained by the Court from Western Health.

15. This finding draws on the totality of the coronial investigation into DM's death including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On 10 September 2022 at around 1.30pm, Mr KL spoke with DM on the phone. She stated that she had been feeling sick and was going to bed. Mr KL told her that he would call her in the morning if he did not hear from her later that evening.

17. On 11 September 2022, Mr KL and his wife unsuccessfully tried to contact their daughter on the phone. They became concerned and at around 5.15pm, they drove to DM's house to check on her. Mr KL subsequently located DM deceased in her bed beside photographs of her children. Mr KL contacted emergency services and Victoria Police and Ambulance Victoria subsequently attended the scene. DM was pronounced deceased at 5.56pm.

18. Victoria Police located a large amount of prescription medication at the scene. They also analysed DM's mobile phone and noted recent internet searches conducted between 8 and 10 September 2022 relating to prescription medication overdose.

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

19. Victoria Police did not find any evidence of suspicious circumstances.

Identity of the deceased

20. On 11 September 2022, DM, born 2 May 1979, was visually identified by her father, KL.

21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine, conducted an examination on 13 September 2022 and provided a written report of his findings dated 10 January 2023.

23. Toxicological analysis of post-mortem samples identified the presence of tapentadol,[3] sertraline,[4] gabapentin,[5] periciazine,[6] carbamazepine,[7] diazepam,[8] zopiclone,[9] promethazine.[10] Dr Bouwer stated that the levels of the drugs detected were consistent with excessive use, the combination of which causes increased depression of the central nervous system and respiratory depression that can lead to severe sedation, coma and death.

24. Dr Bouwer provided an opinion that the medical cause of death was 1(a) Combined drug toxicity (tapentadol, sertraline, gabapentin, periciazine, carbamazepine, diazepam, zopiclone, promethazine).

25. I accept Dr Bouwer's opinion.

[3] Tapentadol is indicated for moderate to severe pain.
[4] Sertraline is an anti-depressant drug for use in cases of major depression.
[5] Gabapentin is clinically used for treatment of partial seizures and neuropathic pain.
[6] Periciazine is used as an anti-psychotic agent.
[7] Carbamazepine is an antiepileptic drug indicated for partial and tonic-clonic seizures, neuropathic pain and bipolar disorder.
[8] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[9] Zopiclone is used in the short-term treatment of insomnia.
[10] Promethazine is an antihistamine.

REVIEW OF CARE

26. DM's case was referred to the Coroners Prevention Unit (**CPU**)[11] for review. The CPU reviewed the coronial brief and relevant medical records and advised that DM's psychiatric assessment during her admission at Sunshine Hospital was reasonable and appropriate. I accept the advice of the CPU.

27. There is no evidence that the Ballarat Group Practice was aware of DM's recent drug overdose and subsequent admission to the Sunshine Hospital and there is no evidence that her discharge summary of 14 September 2022 was sent to them. This information would have been relevant to the treatment options considered by her GPs when she attended the Ballarat Group Practice on 7 and 8 September 2022 and may have influenced decisions to prescribe particular medications. I consider that the discharge summary should have been forwarded to them as soon as possible after DM's discharge from hospital on 6 September 2022.

FINDINGS AND CONCLUSION

28. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was DM, born 2 May 1979;

    b) the death occurred between 10 and 11 September 2022 at 1/58 Elaine Avenue, Alfredton, Victoria, from combined drug toxicity (tapentadol, sertraline, gabapentin, periciazine, carbamazepine, diazepam, zopiclone, promethazine); and

    c) the death occurred in the circumstances described above.

29. Having considered all of the circumstances, including the amount of medication detected in her system, I am satisfied that DM intentionally took her own life.

[11] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) That Western Health review its practices to ensure that discharge summaries for patients who have received treatment for self-harm are promptly prepared and forwarded to their General Practitioners as soon as possible.

I convey my sincere condolences to DM's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

AM, Senior Next of Kin

Western Health

Sergeant Samuel Young, Coronial Investigator

Signature:

Coroner David Ryan

Date : 09 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.