OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Peeta Louise Josephine Edwards**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Gympie
FILE NO(s):	COR 2008/481
DELIVERED ON:	9 June 2010
DELIVERED AT:	Gympie
HEARING DATE(s):	16 February 2010
FINDINGS OF:	M M Baldwin, Coroner
CATCHWORDS:	CORONERS: Inquest – opiate toxicity, inadequate police investigation

Mrs Edwards was born on the 11th of June 1976 and was thus 32 years old at the date of death. She was married and had 4 children. Mrs Edwards had suffered severe depression and early in 2006 she was referred for counselling by her then doctor Dr George Springhall. On the night before and early morning of her death she had been spending time with her 13 year old daughter and they had both stayed up talking and painting toe nails. Her daughter and Mrs Edwards then fell asleep and when her daughter awoke in the morning she was unable to wake her mother. She subsequently telephoned her father who was in Brisbane who advised her to call 000. Mrs Edwards' son rang 000 and the children were advised to commence CPR however they were unable to because rigor mortis had set in.

The Queensland Ambulance Service attended however there was nothing they could do and the police were subsequently called.

The issue to determine in this inquest is what was the cause of death of Mrs Edwards, what were the circumstances surrounding her death and could similar deaths be prevented in the future.

The evidence before me is the police report of the death to the coroner dated the 5th of September 2008 together with a supplementary form one report dated the 16th of July 2009. There are also the orders for autopsy and testing and the autopsy notice as well as the autopsy results as performed by Dr BB Ong. There is also a certificate of toxicology reports from the Forensic Toxicology Laboratory under the hand of M Stephenson as well as an information statement for Dr Ken Morrison. There is also information from Dr Brink, Mrs Edwards' treating General Practitioner as well as referrals to the Gympie Mental Health Team and discharge summaries from the Royal Brisbane Hospital Psychiatric Unit. In addition to this there are a number of statements from Police Officers Steve Carter and John Kane, Queensland Ambulance Transport Paramedic Steven Horne as well as family members Michael John Edwards the husband of the deceased and Sahtesha Edwards, the daughter of the deceased, Dr Bryan Brink, treating General Practitioner and Dr Ken Morrison, the expert in relation to the toxicology reports. There are also a series of photographs taken at the scene by Sergeant John Kane.

It appears that the autopsy showed that Mrs Edwards died as a result of opiate toxicity. Both Morphine and Codeine were detected in the toxicology results. These results showed that the prescribed drug of Epilin was present but in sub-therapeutic levels where as the other prescribed drug of Avanza was above but not to a level that could be considered fatal. The Codeine and Morphine according to Dr Ong were detected in significantly high levels within the known "fatal range". Whilst Codeine can be taken and is known to metabolise to Morphine it generally metabolises to about one tenth of the level of Codeine. In Mrs Edwards' case, because of the high level of Morphine particularly in relation to its parity to the Codeine, it was the opinion of Dr Ong that the Morphine had been taken independently in addition to the Codeine. Other drugs Ibuprofen and Sertraline were also detected but were below the therapeutic range.

Although the autopsy also detected there was severe atherosclerosis involving the coronary arteries particularly in the left anterior descending artery resulting in severe occlusion, this was not considered to be a cause of death although it potentially can cause sudden unexpected death. Dr Ong was of the opinion that the circumstances did not suggest the coronary atherosclerosis was responsible for the death but the toxic mix of the drugs known as opiates causing respiratory depression leading to death usually during sleep was the major cause of her death.

The circumstances surrounding her death are somewhat tragic in that Mrs Edwards was young woman troubled by mental health issues. The report from Dr Brink dated the 12th of March 2009 indicated that Mrs Edwards had been a patient at his surgery since the 23rd of February 2004 and that she had suffered severe depression having experienced her first episode in 2001. Clearly she had an extensive psychiatric background and was in early 2006 referred for counselling by Dr George Springhall. In early 2006 she was referred by Dr Brink to the Gympie Mental Health Team at the Health Service in Gympie. She was referred then to Laurel House and then referred back to her doctor for a repeat of the prescription to assist with insomnia.

On the 27th of April 2006 she had been admitted to the Royal Brisbane Hospital and Royal Children's Psychiatric Unit and was diagnosed with dexamphetamine dependence with undifferentiated mood and anxiety disorders.

During her period at the Royal Brisbane Hospital her detoxification was completed. It was noted that she had a long history of these symptoms and she was placed on medication with some apparent success. She was subsequently referred back to Dr Brink as requiring ongoing psychiatric care and monitor of her treatment and symptoms.

In June of 2006 Gympie Mental Health Service also was seen by the visiting Psychiatrist as part of a cross-sectional review. The visiting psychiatrist, Dr Justin O'Brien, expressed in his letter back to Dr Brinks some concerns about her diagnosis noting a family history with a brother having schizophrenia and one sister having manic depression and another two sisters having depression. He noted though that although there were some features that might be associated with bi-polar affected disorder or psycho thymic personality, he considered it more likely they were a result of childhood experiences and would be best labelled as "emotionally unstable personality traits". He recommended a slow reduction in the psycho tropic medications and on going monitoring.

She seemed to settle down and from 12th of September 2006 until the 8th of January 2008 she had no consultations with her doctor Dr Brink and was presumably stable.

In January 2008 however she again presented with symptoms of depression and at a visit in July of 2008 she admitted to drinking heavily and experiencing one episode of black out with memory loss. At the time she was on Zoloft

(Sertraline) as her anti-depressant and Epilim (Sodium Balproate) as a mood stabiliser. On the 27th of July the Zoloft was changed to Avanza and she was prescribed Temazepam for her insomnia. According to Dr Brink's notes she again saw him on the 4th and 18th of August 2008 but indicated she was feeling better. Although she had a chest infection and was prescribed ventolin and classid antibiotics, her standard medication of Avanz, Epilim and Temazepam were not altered.

Dr Brink considered she had complex psychiatric issues and had suffered several bouts of depression. She had at times abused her children's Ritalin medication as well as alcohol. In the week of her death she had been at home with her four children as her husband had left on the Monday morning to work in Brisbane. The husband had spoken to her and texted her numerous times each day however on the Thursday the 4th of September he noted he had been unable to contact her during the day. He subsequently did speak to her and she had indicated she'd been to gym twice that day but on the second occasion she had had an asthma attack and was feeling unwell. She indicated that she had a headache. She had indicated to her husband she was happy as she noticed improvement in going to the gym but she felt tired and she was putting the children to bed at about 8:30pm that night and going to bed. Although she complained of feeling tired she had indicated that she was fine. Subsequently she did put the younger children to bed but stayed up with her older daughter. The alarm was set for 7:10 in the morning and when the alarm went off her daughter awoke but her mother did not and was in the same position as where she had slept during the night. Her daughter tried to wake her but was unable to and an ambulance was subsequently called.

According to Steven Horne's statement he attended after being despatched by the Maroochydore Communication Centre at 7:15am arriving at 7:28am and were directed to the bedroom inside the house where he found the deceased lying in bed. He noted that no CPR was being undertaken at the time but that the patient was unresponsive, cold to touch and had signs of obvious death due to rigor mortis and pooling of blood. A cardiac monitor was attached to obtain a heart reading but there were nil respirations, absent chest sounds and absent of electrical activity of the heart. There were no obvious signs of injuries although no full examination was carried out. The Queensland Police Service subsequently took over the circumstances.

The police then conducted a search of the house where although it was untidy there were no signs of struggle or any acts of violence. A thorough search was commenced of the dwelling, sheds and vehicle in the shed in regard to any prescribed medication or illicit drugs and photographs were also subsequently taken of the deceased, the main bedroom, items on her bedside table and the main rooms and the boxes of medication prescribed to her. It is noted however that no search was concluded and the police returned to their normal duties and subsequently contacted the husband of the deceased and requested he gather any medication up and bag it for the purposes of providing it to the police at a later time. It is noted it was some 14 months later when the police finally collected a bag with a large assortment of

medications. Although the police report notes in retrospect that the police conducted a search and checked rubbish bin inside the premises but did not thoroughly check the contents of the rubbish in wheelie bins it is clear that no thorough search was carried out. Despite the police report indicating no puncture wounds were found on the deceased's body the autopsy clearly states at page 2 of 5 under signs of recent therapy "a fine puncture mark is present on the crook of the left elbow".

Dr Morrison analysed the toxicology and reported that the high level of Codeine could have contributed a small amount of morphine but if it were representative of blood levels at the time of death the high ratio of free morphine to metabolite suggest that death occurred relatively rapidly after administration. More importantly he noted that the method of administration was probably by injection. It is likely, he said, that oral administration would have produced much higher levels of metabolite though that could have changed post-mortem hydrolysis. He also noted that poisoning due to the inhalation of morphine vapour, known as chasing a dragon, was also possible. It is clear now that the autopsy noted a fine puncture mark and it is more than likely that Mrs Edwards did inject either heroin or morphine, the source of which is unknown. Because a thorough search was not carried out by police no syringe was located and no other drug paraphernalia was located at the scene.

Clearly on the basis of Dr Morrison's report he was of the view the high morphine levels represented a fatal dose although he noted there was no information that would help him draw a conclusion as to what it was and how and when it occurred.

While it is impossible to determine exactly what drugs were injected it is highly probably that either morphine or heroin was injected. The heroin could then have metabolised to the morphine as the morphine present according to Dr Morrison could not have come from the codeine other than a small portion of it.

It is therefore clear that Mrs Edwards died from toxic drug overdose and a toxic combination of drugs. Most likely the fatal dose was of the morphine sourced either from heroin or morphine from an unknown source. As the search by police was inadequate in terms of seizing drugs at the time and looking for drug paraphernalia it is impossible to ascertain whether the drugs were voluntarily administered or not but given the lack of signs of struggle and no corroborating evidence it would appear more likely that it was self administered.