IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1867

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**HEATHER TELFER**
Date of birth:	**20 June 1949**
Date of death:	**Between 9 April 2019 and 14 April 2019**
Cause of death:	**Toxicity to pentobarbitone**
Place of death:	**Parking area on Cape Liptrap Road, Tarwin Lower Victoria 3956 (38º51'03.1"S 145º58'00.8"E)**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Heather Telfer was a 69-year-old mother of two sons, who lived alone at 40 Gibney Street, Maffra Victoria 3860 at the time of her death.

2. On 14 April 2019, Ms Telfer was found deceased in her vehicle in the parking area on Cape Liptrap Road, Tarwin Lower Victoria 3956, map coordinates: 38º51'03.1"S 145º58'00.8"E.

3. Ms Telfer's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria and was considered unexpected and unnatural.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Ms Telfer, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83.

5. Dr Burke commented that the post mortem CT scan showed coronary artery calcification. The external examination was otherwise unremarkable.

6. Toxicological analysis of post mortem blood showed the presence of pentobarbitone[1] and ondansetron[2].

[1] Pentobarbitone is a sedative drug which is used for humane euthanasia of animal. It is not registered for use in humans.

[2] Ondansetron is clinically used to treat nausea and vomiting in post-operative patients and in those receiving cytotoxic chemotherapy and radiotherapy.

Police investigation

7. Upon attending the carpark on Cape Liptrap Road after Ms Telfer's death, Victoria Police investigating officers noted a parked silver Mitsubishi sedan (**the vehicle**) with an elderly female reclined in the driver's seat. Upon checking the registration, the vehicle was confirmed as belonging to Ms Telfer. A coronial investigation was immediately commenced.

8. Leading Senior Constable (**LSC**) Shaun Stirton was the nominated Coroner's Investigator.[3] At my direction, LSC Stirton investigated the circumstances surrounding Ms Telfer's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, witnesses and investigating officers.

9. During the investigation, police learned that Ms Telfer had been estranged from her family for the two years prior to her death. Subsequently, little is known about her social circumstances in the period proximate to her death.

10. Ms Telfer's son, Tyler Telfer, detailed that approximately 12 years prior to her death, Ms Telfer had attempted suicide in a hotel room by taking an overdose of pills. After this attempt, Ms Telfer "was admitted to a mental health facility in Ringwood for two to three weeks".

11. After her discharge from the facility, Ms Telfer moved in with Mr Telfer. Mr Telfer detailed that his mother had been living alone in Porepunkah for approximately two years but had experienced issues with her neighbours. Specifically, she believed that they were trying to kill her. Subsequently, Mr Telfer became involved and the house was sold, with Ms Telfer moving to Melbourne.

12. Ms Telfer moved to Upper Ferntree Gully for approximately six months before moving to Maffra. Mr Telfer purchased the Gibney Street address his mother resided in "around June 2007".

[3] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

13. Ms Telfer knew people in Maffra and the move was a positive one for "a while", with Mr Telfer visiting his mother regularly. Ms Telfer wanted her son to move to Maffra however, at time he met his partner and had a son.

14. Ms Telfer "took issue" with both Mr Telfer's partner's ethnicity and their son, putting Mr Telfer in a difficult position. At the same time, Mr Telfer noticed that his mother was once again experiencing "issues" with her neighbours. "There were indications by Heather that the neighbours were spying on her and coming onto her property." Ms Telfer secured her property, "everything was padlocked and CCTV cameras were installed". Victoria Police also informed Mr Telfer that his mother was "a regular" who was well known to them, having made numerous complaints about her neighbours.

15. Ms Telfer's social alienation is seemingly confirmed by the Clock Tower Medical Centre practice manager, Caroline Driscoll, who detailed that Ms Telfer had no next of kin or emergency contacts on her file and presented as "a bit of a loner". Ms Telfer attended the medical practice from 28 February 2011 to 6 March 2019 and would complain about the doctors not being able to cure her asthma. Ms Driscoll stated that Ms Telfer "would always tell me that nobody cares if she lives or dies…"

16. Ms Telfer's medical history included asthma, chronic breathing problems, dermatitis and reflux. "Her mental health history there was nothing of note except probably being anxious due to the fact no-one would cure her asthma." She was "very adamant" that she wanted a cure for her asthma, despite being a smoker. Efforts were made to explain that there was no cure for asthma but that the condition needed to be managed. "When a new doctor started at the clinic Heather would book an appointment with them and again start the process of trying to have her asthma cured." Ms Telfer was seen by a total of 19 doctors at the medical centre.

17. At a medical appointment on 23 October 2013, Ms Telfer mentioned to her doctor that she was feeling down about her health issues and that she "believed in euthanasia if her quality of life goes bad". Ms Telfer denied having an active suicide plan however, did have fleeting "suicide intentions" because of her health issues. The doctor offered psychotherapy, to which Ms Telfer declined.

18. Approximately five years prior to her death, Ms Telfer indicated to her son that she had suicidal thoughts. "She had used these as a form of veiled threats towards family."

> Heather stated that she was in control of her own life and fully supported euthanasia of her own life. Heather was a supporter of euthanasia rights in society as well. Her background was in medicine. She had worked in this field for twenty years.

19. Ms Telfer had also detailed to her son "her learnings from the past in relation to her suicide attempt".

20. Approximately three years prior to her death, after having been separated for seventeen year, Ms Telfer's estranged husband, John Telfer, reconnected with her. This reconnection gave Ms Telfer the false hope that Mr J. Telfer "would stick around a bit longer" and go on a holiday with her. This did not eventuate because Mr J. Telfer found Ms Telfer difficult to deal with. Specifically, interacting with Ms Telfer "was like walking on eggshells whenever you were around her".

21. In August of 2017, Ms Telfer commenced a trial medication for her asthma that was overseen by the Alfred Hospital. "Only 50 people in Australia had had it…" and involved an injection once a month.

22. On 14 March 2018, Ms Telfer presented to her medical clinic and consulted on a new doctor, detailing that she wanted "to get into Austin Health" because she was certain she needed stem cell treatment to cure her asthma. She had also written to clinics in Thailand and Canada to access stem cell treatment. The doctor referred Ms Telfer to an allergy clinic. The medical clinic never received confirmation that Ms Telfer attended.

23. On 22 August 2018, Ms Telfer again attended her medical clinic in relation to stem cell treatment. Specifically, she requested that the doctor draw blood because she was pursuing stem cell treatment in Switzerland.

24. On 3 September 2018, Ms Telfer again attended her medical clinic and advised the treating doctor that "she had a planned treatment overseas in Serbia to cure her asthma" in four weeks.

25. On 26 September 2018, Ms Telfer again attended her medical clinic and advised the treating doctor that "she had got onto the trial at the Alfred Hospital again, and that she was receiving an injection once monthly". Ms Telfer advised that the injection had initially worked for her however, stopped being affective so she went off the trial and had been off it for the six months prior.

26. On 1 October 2018, Ms Telfer attended her medical clinic again to discuss stem cell treatment for her asthma. Ms Telfer advised that her asthma as "exacerbated". She further advised that she was not being consistent with her medication and was using several different "puffers and preventers", instead of utilising just one. Ms Telfer again detailed being interested in stem cell treatment. The treating doctor detailed their concerns that Ms Telfer was again seeking a cure instead of being open to other asthma management options. She was requested to reattend the following Friday.

27. Ms Telfer did not represent to her medical clinic until 5 February 2019, when she obtained prescriptions for her "Ventolin and preventers". There is a notation on the file referencing stem cell treatment in Switzerland, suggesting the conversation regarding the topic was once again discussed.

28. Ms Telfer's last consultation at her medical centre was on 6 March 2019, for "increased breathlessness in the morning". Ms Telfer advised that she "had increased dizziness and fainting". She further detailed several opinions as to what was causing her symptoms, including heart disease. The doctor noted "that she was clearly over ventilating and gasping, which was not correlated to the asthma". The doctor believed she may have been suffering from anxiety.

29. Despite efforts, Mr Telfer had no direct contact with his mother in the two years prior to her death. Mr Telfer details the estrangement to have been caused by her "appalling behaviour".

> She destroyed all of her local contacts in Maffra. The loss of friendships was over strong opinions that my mother held and this created conflict that could not be resolved.

30. In addition to social isolation, Mr Telfer detailed his belief that the "Christchurch massacre" was a trigger for his mother's decline in mental health. Originally coming from New Zealand, Ms Telfer was said to have become "quite depressed" after the Christchurch massacre. She contacted Mr J. Telfer over the incident and several other issues. Mr J. Telfer reiterated Ms Telfer's distress over the incident to their son. "Heather had always seen Christchurch as her spiritual home and may have wanted to return there one day."

31. On 14 April 2019 at approximately 11.10am, LSC Stirton received a request to attend the parking area off Cape Liptrap Road due to reports of a deceased female in a vehicle.

32. LSC Stirton arrived at approximately 11.55am and was met by Fisheries Officer, Steve Bosch. Mr Bosch advised that he had seen the vehicle parked in the same spot the day prior and had assumed that the driver was asleep. Upon returning to the location and noting the same vehicle with the same driver in the front seat, Mr Bosch took a closer look and discovered the driver was deceased.

33. Paramedics were already in attendance and confirmed to LSC Stirton that the female was deceased.

34. Upon closer inspection of the vehicle, a sheet of A4 paper in a plastic sleeve was located on the front passenger seat. The paper was titled, "This is my last wish regarding funeral arrangements of me, Heather Elizabeth Yvonne Telfer." It was dated 9 November 2011 and signed by Ms Telfer and witnessed by two court registrars. Several other means of identification were also in the vehicle.

35. A handwritten note was also located in the front pocket of Ms Telfer's jeans. The note detailed steps/ instructions on taking one's own life. These included, the taking of an anti-vomiting drug "2 days before" and "10 gm or more into a glass adding 50 ml of cold water. Stir until powder fully dissolved + liquid in glass is clear… only a few minutes of consciousness sleep… death follows – 1-2 hours."

36. These instructions seemingly correlate with the results found at Ms Telfer's post mortem toxicological analysis.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I note that the annual frequency of pentobarbitone related deaths has fluctuated over recent years. The range of fluctuation is significant, with one death in the year 2012 to 18 deaths in the year 2015.

2. Research has not identified any evident underlying trend, save for the highest frequency of deaths being in persons aged 65 years and older. I also note that more females have died by way of this mechanism than men.

3. The evidence collected throughout the coronial investigation, particularly the reference to "powder" in the handwritten instructions, suggests that the pentobarbitone was originally imported from overseas.

4. Coroners have previously investigated prevention opportunities with respect to imported pentobarbitone. Coroner Paresa Spanos concluded her Finding into the 2014 death of Joseph Waterman[4] that,

> The CPU has struggled to identify any opportunities for preventing pentobarbitone suicide in Victoria through further restricting access either to pentobarbitone or restricting access to information about its use in suicide:
>
> a. Pentobarbitone regulation is appropriate. It is banned for human use in Australia, cannot legally be imported, and only veterinarians are allowed access to it. Possible veterinarian access could be tightened further, however the data available to the CPU suggests most suicides involved pentobarbitone imported from overseas rather than sourced locally from veterinarian supplies.
>
> b. Suicide organisations' publications advocating specific suicide methods (including pentobarbitone use) are banned in Australia but there is no practical way to prevent Australians from viewing and accessing them via the internet.
>
> c. The Australian Customs and Border Protection Service is well aware that people attempt to import pentobarbitone illegally into Australia to assist in suicide, and has released a public information sheet regarding this practice. There is probably no recommendation a Victorian coroner could

[4] COR2014 0169

make that would realistically assist the Australian Customs and Border Protection Service further in the task of detecting illegal imports.

5. Similarly, in another investigation the Coroner commented in her Finding into the 2015 death of Leonard Tuia[5],

> It is difficult to identify any opportunities for preventing pentobarbitone suicide in Victoria through further restricting access either to pentobarbitone or to information about its use in suicide. Current pentobarbitone regulation is appropriate; it is banned for human use in Australia, cannot be legally imported and only veterinarians are allowed access to the drug. It is possible that veterinarian access could be further restricted, however, the evidence before me regarding Mr Tuia's death is that his access to the drug was via importation from overseas rather than being obtained locally from veterinarian supplies. Data from the Coroners Prevention Unit (CPU) also suggests that most pentobarbitone toxicity deaths involve importation from overseas. Publications such as the one accessed by Mr Tuia are banned in Australia but there is no way to prevent Australian residents from viewing such content online. The Australian Customs and Border Protection Service is well aware that people attempt to import pentobarbitone illegally into Australia to assist in suicide, and has released a public information sheet addressing the matter.

6. The matters identified in the previous Coronial Findings as well as in the investigation into the death of Heather Telfer, are representative of a risk to public health and safety but unfortunately, the issues and identified problems remain unchanged. Accordingly, I make no further commentary or recommendation in this matter.

[5] COR2016 1667

FINDINGS

1. I find that Heather Telfer, born 20 June 1949, died between 9 April 2019 and 14 April 2019 in her vehicle in the parking area on Cape Liptrap Road, Tarwin Lower Victoria 3956, map coordinates: 38º51'03.1"S 145º58'00.8"E.

2. Although the exact precipitating factors that led Heather Telfer to adopt the action of illegally accessing pentobarbitone are not known, the investigation has identified that she had become socially isolated and was consumed with her desire to find a cure for her asthma, while never completely following the advice of her medical practitioners in respect of the same.

3. I accept and adopt the cause of death ascribed by Dr Michael Burke and I find that the cause of Heather Telfer's death was toxicity to pentobarbitone in circumstances where I find that she intended to end her own life.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Tyler Telfer

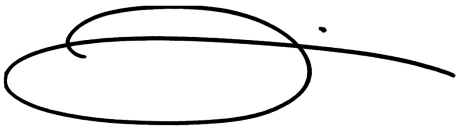
The Proper Officer, Australian Border Force

The Hon Peter Dutton, Minister for Home Affairs

The Hon Jason Wood, Assistant Minister for Customs, Community Safety and Multicultural Affairs

Leading Senior Constable Shaun Stirton

Signature:



AUDREY JAMIESON

CORONER

Date**: 28 August 2020**