CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Wayne Brian Mullin
Hearing dates:	25 September 2023
Date of findings:	25 September 2023
Place of findings:	Lidcombe
Findings of:	**Magistrate Kennedy** **Deputy State Coroner**
Catchwords:	CORONIAL LAW – unascertained death, affects of splenic toxicology, effects of oxycodone and diazepam on respiratory illness, effects of significant decomposition affecting autopsy
File number:	2021/298599
Representation:	Mr Durand Welsh, Advocate Assisting

Findings:	I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW): **The identity of the deceased** The deceased person was Wayne Brian Mullin **Date of death** Between 21 September 2021 and 20 October 2021 **Place of death** 703/149 Cope Street, Waterloo, New South Wales **Cause of death** Complications of eosinophilic asthma with bronchiectasis and allergic broncho pulmonary aspergillosis in a setting of oxycodone and diazepam use. **Manner of death** Misadventure (drug toxicity impacting underlying natural causes)
Recommendations:	I make no recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW)

Coroner's Role

1. Section 23 of the Coroners Act 2009 allows a senior coroner jurisdiction to hold an inquest concerning the death of apers if it appears that the person died with in lawful custody. Section 27 of the Act makes the holding of an inquest mandatory in this case.

2. Inquests are not adversarial, but inquisitorial. The purpose of an Inquest is not to attribute blame or punish anyone, but rather to investigate how and why a person

died, and to find mechanisms, if possible, to stop preventable deaths. These requirements are also found within section 27 of the Act. Section 81 requires the identify, time, date and place be found. Importantly the inquest should disclose the cause and manner of a person's death.

Background

3. This is an inquest into the death of Mr Wayne Mullin, who was located deceased on 20 October 2021 at his home.

4. At the time of his death, Mission Australia were assisting Wayne Mullin with his accommodation, living needs, and health concerns. His support facilitator was Ms Nina Ferrel. She began assisting him on 23 August 2019 and in November 2019 she helped him obtain accommodation at 703/149 Cope Street through the Department of Communities and Justice.

5. She initially saw him two to three times per week, although during the COVID-19 pandemic this decreased significantly and it became routine for her to contact him via mobile phone instead.

6. Wayne was often difficult to reach by telephone and at it was not unusual for Ms Ferrel to be unable to contact him for a periods of time although generally she would interact with him on a monthly basis utilising phone calls, text message or email.

7. In October 2021, Ms Ferrel was attempting to reach Wayne to discuss him receiving ongoing support from other services as the Mission Australia program supporting their relationship was due to end.

8. On the 18 October 2021 she sent him a text message offering him food vouchers to return her calls. She sent another text message on the 19 October 2021 offering food vouchers. She had previously used this as a mechanism to encourage a response from Wayne, but she received no response to either message.

9. On the 20 October 2021 she contacted his Department of Communities and Justice case manager who sent security from 149 Cope Street to his unit to check on him. They indicated to his Department of Communities and Justice case manager, that they could not raise anyone inside and there was uncollected mail in his letterbox.

10. Ms Ferrel then contacted 000 to report her concerns for Wayne's welfare.

11. On the 20 October 2021, about 5:20 pm, police attended 703/149 Cope Street. The premises consisted of two bedrooms, one bathroom and a combined living/kitchen area with an attached balcony. Police forced entry to the unit and found Wayne lying face up on his bed in the main bedroom with his laptop beside him.

12. At 6:47 p.m., police detectives Evans and Doyle attended the location. They determined that nothing appeared suspicious.

13. About 8:30 p.m. Crime Scene Officers Ostojic and Vcaar attended the location and examined the scene. Several medications were located within the unit, including the following: Nicorette pills, Spiriva, Sucralfate, Lithium Carbonate, Potassium Chloride, Frusemide, Prednisolone, Circlesonide, Ipratropium, Colecalciferol, Doxepin, Venlafaxine and Champix.

Autopsy report

14. Dr Pokorny conducted the post-mortem examination. Decomposition changes were present. Within this limitation, no acute injuries were seen externally or on internal examination. The internal organs showed decomposition change. No other significant abnormalities were identified.

15. Toxicological analysis of splenic blood detected alcohol at 0.036 g/100 ml, at least part of which may be due to post mortem artefact.

16. Quetiapine, oxycodone and its metabolite oxymorphone were detected in splenic blood at levels that, if they had been detected in femoral blood, would be considered lethal range. However, no reference ranges are available for these drugs in splenic blood.

17. Lithium was detected at 0.10 mg/kg. The significance of this result is also uncertain. Modest levels of diazepam and its metabolites were also detected.

18. The cause of death remained unascertained after post mortem examination, likely due to the obfuscating effects of decomposition. Although multiple medications were present at potentially high levels, in the absence of reference ranges for splenic blood (and the possibility of drug accumulation or post mortem redistribution affecting results from this site), the significance of these results is uncertain. Within the limits of the examination due to decomposition, no significant potentially lethal natural disease or injuries were identified.

Wayne Mullin's Medical History

19. Wayne Mullin's treating General Practitioner was Associate Professor Marilyn McMurchie, who operates out of East Sydney Doctors at 102 Burton Street, Darlinghurst. Dr Anthony Byrne, a thoracic medicine specialist who operates out of St Vincent's Clinic in Darlinghurst, was also providing specialist care to Wayne in relation to several respiratory issues.

20. Professor McMurchie's records show that Wayne suffered from the following active conditions:
    a. Eosinophilic asthma
    b. Allergic bronchopulmonary aspergillosis
    c. Bronchiectasis
    d. Depression
    e. Bipolar Affective Disorder
    f. Obstructive Sleep Apnoea
    g. Rectus Sheath haematoma
    h. Osteoporosis
    i. Hypercholesterolaemia
    j. Iron deficiency
    k. Anaphylactic reaction
    l. Gastro-oesophageal reflux disease
    m. Severe anaphylaxis in relation to nut allergies

21. Wayne's medical history discloses multiple hospitalisations in relation to severe respiratory ailments.

22. In particular, medical records indicated that Wayne Mullins suffered from severe eosinophilic asthma with Chronic Obstructive Pulmonary Disease overlap syndrome on a background of severe sleep disordered breathing. He was last admitted to hospital on 1 March 2021 for treatment of his asthma. Prior to this admission, he had had approximately five admissions to hospital on a similar basis. He also suffered from Bipolar affective disorder and was on extensive psychotropic medications for same. The records also disclose that in 2017 he was known to have suffered a pulmonary haemorrhage with angioembolisation.

23. Professor McMurchie's last face-to-face consultation with Wayne occurred on 18 August 2021. On this date he received his first Pfizer vaccine dose and 300 mg of dupilumab. The Pfizer vaccine was at the recommendation of Dr Byrne, who recommended he be vaccinated "with alacrity". Professor McMurchie indicates that an Advanced Care Directive was discussed and that Wayne seemed well organised

with his asthma plan. This was the last time that Professor McMurchie saw Wayne face-to-face.

24. Notably, of the drugs detected in toxicology, neither oxycodone nor diazepam appear within the list of his current medications known to Professor McMurchie in the records relating to her final consultation with him on the 18 August 2021. However, within the medications located at the premises was an opened packet of Endone with a date of 27/08/2021 and the prescriber as Dr McMurchie. Although not listed on his current medication schedule, Endone (oxycodone) has been consistently prescribed to Wayne through Professor McMurchie since at least 2019.
25. Professor McMurchie had one further consultation after 18 August 2021, and this occurred via telehealth on 25 August 2021. The records for this date are brief and indicate that on this date Wayne received a renewal of his EpiPen prescription.

26. On 11 August 2021, on the consultation prior to the last face-to-face meeting on the 18 August 2021, Professor McMurchie raised concerns that Wayne had previously missed four doses of his monthly dupilumab injections. Dr Byrnes had prescribed the dupilumab for Wayne's severe asthma.

27. Reasons for him missing the dosages are unclear, but Professor McMurchie's notes indicate that at times it was difficult to reach Wayne. A "Team Care Arrangements" form within Professor McMurchie's records indicates that as part of a collaboration with Dr Byrnes, Wayne was to be reviewed every two weeks for injection of dupilumab.

28. Therefore, in the vicinity of his death, there appears to have been some lack of compliance with his currently prescribed asthma medications.

29. With regards to Wayne's mental health, an entry on the 11 August 2021 details a "Mental Health Treatment Plan". His mood is described as low but there are no references to suicidal ideation or self-harm within the treatment plan. The "Chronic Disease Management Plan" dated 30 June 2021, indicates that chronic suicidality was present since the breakup of his marriage and his diagnosis of Bipolar Affective Disorder in 2019.

30. The "Mental Health Treatment Plan" detailed two previous attempts at suicide. One in Manly approximately 6 years prior to the date of the plan, and one in November 2019. Further details about the attempts are not disclosed within the treatment plan itself.

31. However, it should be noted that the St Vincent's Hospital medical records for the November admission, which occurred on 5 November 2019, do not disclose any actual suicide attempts. On that date, Wayne was initially conveyed to St Vincent's Hospital suffering shortness of breath over the previous three days. The records indicate that Wayne informed staff that thoughts of self-harm and suicidal ideation had recently escalated and that if he were not in hospital he would attempt to take his own life by overdosing.

32. He was consequently admitted to Caritas Acute Mental Health Unit, where he presented with low mood, insomnia, and thoughts of suicide with no plan or intent. He was discharged on 20 December 2019.

33. While the majority of his admissions relate to severe asthma, he was also admitted to St Vincent's Hospital on 17 October 2019 for chronic lithium toxicity, lithium being one of his prescribed medications. The discharge summary suggests that the lithium toxicity did not relate to any intentional overdose. It was noted that lithium serum concentrations could increase due to variables relating to the kidneys.

34. The last hospital admission for Wayne Mullin was a 10-day admission to Royal Prince Alfred Hospital beginning on 1 March 2021 for non-infective exacerbation of eosinophilic asthma. He was initially treated within the Intensive Care Unit, before being transferred to the ward. He was also suffering central, sharp chest pain on arrival, but his troponins were non-dynamic and his chest pain resolved. The record indicates that Wayne's type 2 respiratory failure was resolved during the admission.

35. On 22 October 2021, Professor McMurchie records within her medical records that she was advised by police of Wayne's death. She subsequently discussed the case with Dr Byrne, and after discussion she felt able to offer an opinion that the cause of death was due to the acute respiratory failure with the following antecedent causes: chronic respiratory failure; eosinophilic asthma; bronchiectasis; aspergillios, allergic broncho pulmonary (ABPA).

36. Other significant conditions were bi-polar affective disorder, anaphylaxis and pulmonary embolism occurring in 2017. However, this opinion was offered prior to the toxicology results becoming available.

Dr Pokorny – expert opinion on cause of death

37. Dr Pokorny found after autopsy that the cause of death was unascertained. However since that time she has had the benefit of the medical records which were not originally available to her. In her evidence, she noted that when undertaking toxicology testing, ideally a femoral blood sample is taken and sent for testing. As a result of the decomposition she was not able to obtain that sample and instead was able to obtain a splenic blood sample.

38. While she notes that this result can be helpful for identifying illicit drugs or medications taken by an individual, it is not testing routinely performed elsewhere and there is no available published data on expected drug levels within that sample. Dr Pokorny noted that the levels found, although some would be lethal if found in a femoral sample, are unable to be properly interpreted. However, she was able to explain that in Mr Mullin's case any amount of oxycodone and diazepam would be contraindicated given his very serious respiratory condition.

39. On that basis I am satisfied that these drugs did play a part in his death, given the likely exacerbation of his underlying respiratory illness.

40. Dr Pokorny was able to find the cause of death on balance of probabilities as being complications of eosinophilic asthma with bronchiectasis and allergic broncho pulmonary aspergillosis in a setting of oxycodone and diazepam use.

Identity, Time and Place of Death

41. In relation to the confirmation of Wayne Mullin's identity, Detective Leading Senior Constable Simon Searles of Fingerprint Operations confirmed Wayne Mullin's identity through comparisons made of right and left thumb impressions with filed fingerprints maintained at the New South Wales Police Force, Fingerprint Operations, Parramatta.

42. While the time of death is unknown, the last reliable evidence indicating Wayne Mullin as being alive was a phone call occurring at 4:09 p.m. on the 21 September 2021. All phone calls after this date go unanswered. When police attended on the 20 October 2021, he was deceased.

43. In relation to the place of Wayne's death, his death occurred within his home address at unit 703 of 149 Cope Street, Waterloo.

44. After a thorough investigation by police there were no indications of suspicious circumstances or foul play. The Autopsy report also supports this position.

Acknowledgements

Thank you to Mr Welsh, Coronial Advocate assisting for a thorough and careful preparation, attention to detail and appropriate submissions made to assist in this inquest.

Findings

I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased
The deceased person was Wayne Brian Mullin

Date of death
Between 21 September 2021 and 20 October 2021

Place of death

703/149 Cope Street, Waterloo, New South Wales

Cause of death

Complications of eosinophilic asthma with bronchiectasis and allergic broncho pulmonary aspergillosis in a setting of oxycodone and diazepam use.

Manner of death
Misadventure (drug toxicity impacting underlying natural causes)

I make the no recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW)

Conclusion

I extend my sincere condolences to the family and friends of Mr Wayne Mullin and I now close this inquest.