CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of CL
Hearing dates:	31 July 2026
Date of findings:	15 September 2026
Place of findings:	Coroner's Court of New South Wales
Findings of:	Judge David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – homicide, long time care by family member
File number:	2018/00281118
Representation:	Coronial Advocate Assisting: Sergeant Perry

Findings:

Identity:

The person who died was CL

Date of death:

Between 11 and 12 September 2018

Place of death:

Taree, NSW.

Cause of death:

Amitriptyline toxicity

Manner of death:

Homicide

Protective orders: Non-publication and pseudonym orders have been made in this inquest. A copy of the orders is available upon request from the Court Registry.

Introduction

1 On 12 September 2018 CL was found deceased in her bedroom by her sister, [redacted], shortly after 7.20am. CL was 59 years of age. CL's mother and primary carer, [redacted], was also found deceased that morning in the lounge room of the same premises.

Inquest

2 A short inquest was held on 31 July 2026.

3 There was no oral evidence at inquest.

4 Exhibit 1 in the inquest was the brief of evidence prepared by Detective Senior Constable Peter Shedden, the officer-in-charge of the coronial investigation. The material gathered during that investigation has been considered in making my findings.

5 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing.

6 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the *Coroners Act 2009* (NSW) (the Act); namely:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death.

7 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

Background

8 CL was born on [redacted]. She lived with profound intellectual and physical disability throughout her life. CL required constant full-time care. She was unable to talk, walk, feed herself, bathe herself or to use the toilet independently or swallow without assistance. CL's sister described CL's functional abilities as equivalent to those of a very young infant.

9 CL lived for many years at [redacted], Taree. Her day to day care was provided principally by her mother, [redacted], who had cared for CL since birth.

10 The evidence revealed that the care required was extensive, physically demanding and constant. In later years [redacted] own health deteriorated, and family members provided increasing assistance. NDIS records reveal substantial approved funding for core supports, capacity building supports, assistive technology, home modifications and support coordination. Records also reveal that only part of the funding had been spent.

Circumstances leading to death

11 In the days before 12 September 2018 family members had been assisting [redacted] with CL's care. [redacted] was experiencing significant pain and had difficulty physically moving CL in and out of bed. [redacted] attended the home on 10 and 11 September 2018 to help with CL's care, including assisting with getting CL out of bed in the morning and putting her to bed at night. On the evening of 11 September 2018 [redacted] attended [redacted] helped [redacted] put CL to bed and then left at about 8.30pm. About 7.20am on 12 September 2018 [redacted] returned to the home. She entered through the rear door using her key.

12 She saw [redacted] seated in a chair in the lounge room with a plastic bag covering her head. [redacted] was cold to touch. [redacted] then went to CL's bedroom and found CL lying in bed also cold to touch. [redacted] contacted her partner and then called Triple-0. Police attended shortly after. Senior

Constable Grimmett and Sergeant Atkinson entered the premises and located [redacted], deceased, in the lounge room. They then located CL deceased, in a rear bedroom. CL was in bed covered by blankets with only part of her face and her right hand visible. Police observed no signs of forced entry and the premises appeared neat, tidy and undisturbed.

13 A handwritten note was located on the kitchen table. In substance it was addressed to the family and stated, "Please forgive me but I can't carry on. I have too much pain and I'm too tired. I love you all. Please try to understand. Love, Mum." Followed by four lower case x's or crosses. The premises were declared a crime scene.

14 A crime scene warrant was obtained and executed later that morning. Crime scene officers attended and examined the premises. Police also conducted neighbourhood canvassing and made inquiries with family members. Those inquiries disclosed that [redacted] had previously made comments to the effect that she would not leave CL as a burden on the family, and that she had also made comments over the years about taking her own life.

15 A post-mortem examination was conducted by Dr Allan Cala at the Department of Forensic Medicine Newcastle on 17 September 2018. Dr Cala concluded that CL died on 12 September 2018 and that the cause of death was amitriptyline toxicity. The post-mortem report also recorded significant underlying conditions of intellectual impairment and cerebral palsy. There was no evidence of injury on external or internal examination.

16 Toxicological analysis identified amitriptyline and nortriptyline in CL's blood at very high levels, described by Dr Cala as being within the reported fatal range for overdose. Dr Cala noted that given CL's circumstances and dependency she would have been unable to self-medicate. He therefore expressed the view that the presumption was that excessive amitriptyline had been administered to CL directly leading to her death.

Findings section 81 Coroners Act 2009

17 As submitted by the coronial advocate assisting, the surrounding circumstances provide support for a finding of homicide. CL was found deceased in her bed within a locked and secured residence. Her mother, [redacted], was located deceased elsewhere in the home. A handwritten note of [redacted] expressing an inability to continue due to pain and exhaustion was located on the kitchen table. Police found no evidence of forced entry or third party involvement.

18 A finding of homicide is not a finding of criminal responsibility. It is not my role to determine criminal responsibility. In this context homicide means killed by another person without determination of criminal responsibility.

19 Having considered all the evidence, the findings I make under section 81(1) of the Coroners Act 2009 (NSW) are:

Identity:	The person who died was CL.
Date of death:	Between 11 and 12 September 2018.
Place of death:	Taree, New South Wales.
Cause:	Amitriptyline toxicity.
Manner of death:	Homicide

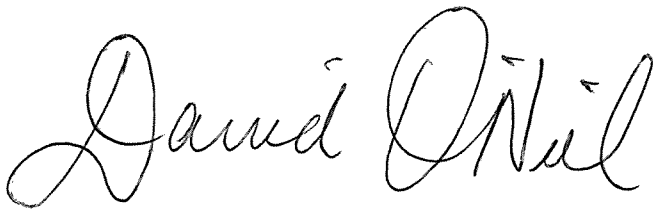
Conclusion

20 On behalf of the Coroner's Court of New South Wales, I offer my sincere condolences to CL's family and friends.

21 I would like to thank the officer in charge, Detective Senior Constable Shedden for leading the coronial investigation and for his work in the preparation and provision of the brief of evidence.

22 I also acknowledge and express my gratitude for the assistance of the Coronial Advocate, Sgt Perry, in the preparation for, and the running of, this inquest.

23 I close this inquest



Judge David O'Neil
Deputy State Coroner
Coroner's Court of New South Wales
15 September 2026