CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Christiaan Rudolf DE WET**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Christiaan Rudolf DE WET
Late of:	13 Forest Hill Road Henderson Auckland
Occupation:	Mental Health Nurse
Sex:	Male
Date of Birth:	09 May 1976
Place of Death:	North Shore Hospital Shakespeare Road Takapuna Auckland New Zealand
Date of Death:	22 April 2017
Cause(s) of Death	
(a). Direct cause:	Cardiac event
(b). Antecedent cause (if known):	Myocardial ischaemia
(c). Underlying condition (if known):	Narrowing of coronary arteries by atherosclerosis
(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known):	High nortriptyline levels in the blood

Circumstances of death:

I find that Christiaan Rudolf de Wet died at North Shore Hospital, Auckland on 22 April 2017. The cause of his death was a cardiac event secondary to myocardial ischaemia and narrowing of coronary arteries by atherosclerosis in association with high nortriptyline levels in the blood.

I do not consider Mr de Wet's death to have been in circumstances amounting to suicide.

Exceeding the prescribed dosage of medication to a potentially toxic level is readily and commonly understood by the public as having potentially adverse and even fatal outcomes. Less obvious to even a long-term medication user may be the risk an excessive dosage presents in terms of exacerbating underlying natural disease, and thereby causing death. As a tricyclic antidepressant nortriptyline is reported to be recognised as being less safe in overdose than the SSRI sertraline. Compliance with the prescribed dosage is therefore critical and medical input should be sought rather than resort to self-

medicating in excess of the prescribed dosage. Given the nature of these observations, I do not consider that there are any formal recommendations required.

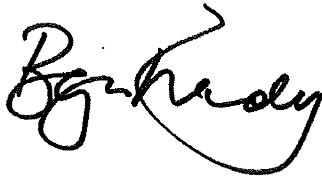
A copy of this Finding will be sent to the Centre for Adverse Reactions Monitoring (CARM) for informational purposes.

Restrictions on publication

Pursuant to **section 74** of the Coroners Act 2006, I am satisfied it is in the interests of decency and personal privacy to prohibit the publication of photographs of Mr de Wet taken during the investigation into his death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

Those findings, and my reasons for making them, are also set out in my written findings dated: 2 June 2021.

Signed at Wellington on 2nd day of June 2021.



Coroner B Windley

THIS FINDING IS SUBJECT TO PROHIBITIONS AND RESTRICTIONS ON PUBLICATION UNDER S 74 OF THE CORONERS ACT 2006

IN THE CORONERS COURT
AT AUCKLAND
(IN CHAMBERS)

CSU-2017-AUK-000487

UNDER	**THE CORONERS ACT 2006**
AND	
IN THE MATTER OF	**An inquiry into the death of Christiaan Rudolf de WET**

Date of Findings: 2 June 2021

FINDINGS OF CORONER B WINDLEY

Introduction

[1] On 22 April 2017 Christiaan Rudolf de Wet died at North Shore Hospital ICU having been transferred from Waitakere Hospital the previous day after being found convulsing at his home in Henderson, Auckland.

[2] Mr de Wet's death was reported to the coroner and an inquiry was opened.

Cause of death

[3] On 24 April 2017 pathologist Dr Duncan Lamont performed a post mortem examination of Mr de Wet.

[4] In the course of the examination Dr Lamont found a severe narrowing of the left anterior descending coronary artery (up to 80%). Mr de Wet's right coronary artery also showed narrowing by atherosclerosis (up to 40%).

[5] A sample of Mr de Wet's femoral blood was analysed by Wendy Popplewell, a forensic toxicologist from the Institute of Environmental Science and Research (ESR). Analysis identified the presence of a number of medications in Mr de Wet's blood, including paracetamol, zopiclone (a hypnotic and sedative used to treat insomnia), quetiapine (an antipsychotic), topiramate (an anticonvulsant for epilepsy), sertraline (an antidepressant), lignocaine (an anaesthetic), rocuronium (a muscle relaxant) and nortriptyline (an antidepressant with sedative properties). Ms Popplewell commented that many of these medications have a depressant effect on the central nervous system, and their combined use is likely to enhance this effect.

[6] Ms Popplewell reported the levels of zopiclone, quetiapine and sertraline in Mr de Wet's blood were consistent with normal use. However, she found that paracetamol was at a level slightly higher than expected for normal use. The level of nortriptyline was reported as within the range associated with nortriptyline-related fatalities. Ms Popplewell referenced four nortriptyline-related deaths analysed by ESR in which femoral blood concentrations of nortriptyline were between 3.3 to 5.3 mg/L. She stated that the level of nortriptyline in Mr de Wet's femoral blood (3 mg/L) was consistent with nortriptyline fatalities reported in scientific literature.

[7] Noting the toxicology results, Dr Lamont's initial conclusion was that Mr de Wet's death was due to toxic levels of nortriptyline and myocardial ischaemia as a result of atherosclerosis.

[8] I subsequently provided Dr Lamont with the background evidence set out below, and sought further clarification as to the cause of Mr de Wet's death; whether it was due to a self-inflicted overdose of nortriptyline (whether intentional or accidental), or alternatively the nortriptyline exacerbated Mr de Wet's underlying susceptibility to sudden cardiac death due to his natural diseased state. In his further response, Dr Lamont stated:

> I have studied the information available and agree that the overdose of nortriptyline appears to have exacerbated an underlying ischemic, and therefore

> unstable, myocardium. I note that Mr de Wet complained of chest pains (a characteristic feature of myocardial ischaemia) and thought that it was a panic attack. We cannot exclude the fact that he took the nortriptyline in an attempt to alleviate this symptom.
>
> This history of chest pain, the severe narrowing of the coronary arteries, severe pulmonary oedema all point towards myocardial ischaemia. He was in hospital and said to be improving. He was also under treatment for nortriptyline overdose and despite this he developed ventricular fibrillation.
>
> All things considered, I feel the picture is dominated by the natural disease.
>
> In light of this additional information, I feel that the nortriptyline is of much less significance than I initially determined.

[9] Dr Lamont provided a revised autopsy report recording the cause of Mr de Wet's death as cardiac event secondary to myocardial ischaemia and narrowing of coronary arteries by atherosclerosis in association with high nortriptyline levels in the blood. Dr Lamont summarised:

> Autopsy examination revealed that the cause of death was due to myocardial ischaemia as a result of atherosclerosis. Significant levels of nortriptyline were detected in the blood and may have exacerbated his condition.

[10] I accept Dr Lamont's opinion

Circumstances of death

Personal circumstances

[11] At the time of his death Mr de Wet was 40 years old and worked as a psychiatric nurse in the psychiatric inpatient unit of Waitakere Hospital. He was born in South Africa but moved with his then partner, Sean McNeilage de Wet, to New Zealand in 2011. They had been in a civil union since 2009 but separated in late 2015. Mr de Wet had been in a relationship with David Vail for around 10 months prior to his death.

Medical and mental health background

[12] Dr Edwin Yip, a GP at the Doctors Massey Medical, provided a report for my inquiry. Dr Yip reported that Mr de Wet had a history of chronic depression (since 1995),

epilepsy (since 2004), asthma, fatty liver and high cholesterol. Mr de Wet was a smoker who reported a moderate intake of alcohol and had a family history of heart disease. Mr de Wet's regular prescription medications were nortriptyline (three 25mg tablets at night), topiramate, zopiclone, seretide, and salbutamol.

[13] Mr de Wet had last consulted his regular GP, Dr Joy Stevens, in July 2016 with a complaint of having some wheeze and chest tightness on exertion and occasional central chest discomfort. Clinical notes record "asthma, bronchitis, depression/?angina (unlikely)". An electrocardiogram (ECG) and troponin levels were unremarkable. Mr de Wet was referred to the cardiology service although Dr Yip reported the cardiology service advised that Mr de Wet had cancelled his scheduled appointments in January and March 2017. Mr de Wet's clinical notes do not record any further complaints of chest pain or discomfort by Mr de Wet.

[14] Waitemata District Health Board Consultant Psychiatrist, Dr Shirley Walton, also provided a report for my inquiry. Dr Walton detailed that Mr de Wet had a history depressive episodes since age 16 and had been trialled on a number of medications but experienced side-effects with each. Dr Walton referred to Mr de Wet taking a "serious overdose of benzodiazepines" in 2004 following which he sustained a number of medical complications eventually requiring a tracheal resection.

[15] Mr de Wet was first referred to Specialist Mental Health and Addiction Services (SMHAS) in October 2015 following an assault by a client at work. He reported other significant stressors in his life including the state of his relationship with his spouse and the likelihood of a separation. At that time he was taking 100mg of sertraline and declined further follow-up.

Engagement with SMHAS and Dr Yip: November 2016 – April 2017

[16] Mr de Wet was again referred to SMHAS for an assessment in November 2016 and was reviewed by Dr Walton for complaints of severe fatigue and low energy levels, poor sleep and psycho-social stressors. The referring clinician had concerns about Mr de Wet's poor concentration at work and extent of sick leave, although this was understood to have improved. Dr Walton's clinical impression was of a current major depressive

episode of moderate severity with notable fatigue and lethargy and generalised anxiety in spite of current treatment with sertraline.

[17] Dr Walton reported precipitating factors of multiple stressors over the past year or so including the break-up of his civil union partnership, ongoing concerns about his ex-partner, work stressors, family health concerns, and family being overseas. Dr Walton noted that Mr de Wet's epilepsy appeared well controlled with topiramate which, despite being known to cause lethargy, was the best medication for Mr de Wet's seizure control and tolerability. Other predisposing factors were identified by Dr Walton, including a 24 year history of depressive episodes, family stressors in his childhood and teenage years. Maintaining factors were recorded as breakthrough symptoms on his current medication, inadequate nutrition and sleep, not helped by shift work. Protective factors included that Mr de Wet was engaged with his GP regularly, he had very good insight, and was continuing to work full time. He was also actively seeking psychological help, he was well informed and intelligent with good relationships with others. There was no evidence of personality disorder. Dr Walton's recorded impression was that "Mr de Wet was sensitive, hardworking, quite perfectionistic and possibly quite hard on himself."

[18] It appears that a switch from sertraline to nortriptyline was initiated. Dr Walton recorded: "We noted he had no suicidal thoughts and was adamant he would not ever attempt suicide again as he had "learned my lesson" after complications following his history of one precious suicide attempt over 10 years before."

[19] On subsequent review by Dr Walton on 23 December 2016, Mr de Wet reported a significant improvement, his concentration had improved, he had no suicidal thoughts but had ongoing anxiety and continuing stressors. Mr de Wet had no active suicidal ideation and was definite that he would not make a second suicide attempt. Mr de Wet had been able to stop his quetiapine which was likely adding to his fatigue and Dr Walton expressed hope that his zopiclone could also be stopped. Dr Walton's impression was that Mr de Wet had had a good initial response to nortriptyline with an improvement in most symptoms.

[20] Mr de Wet was further reviewed by Dr Walton on 20 February 2017. He reported generally feeling much better. He had no suicidal thoughts but was still having panic attacks. A trialled increase in his nortriptyline dosage from 75mg to 100mg had worsened

his blurred vision so it was decided to maintain the 75mg daily dose. Dr Walton reported Mr de Wet's nortriptyline levels were well within therapeutic levels. Mr de Wet thought it reasonable to be transitioned back to GP care with the knowledge he could call the Referral Management Nurses at any time if he experienced any problems.

[21] On 14 March 2017 Mr de Wet self-referred back to SMHAS reporting he felt he was no longer experiencing therapeutic effect from his antidepressant medication and was feeling alternatively anxious, a little low in mood, then good mood, on a three-day cycle. He reported taking his medication regularly. Dr Walton suggested he explore further therapy sessions facilitated through his workplace and when contacted by a nurse on 18 March 2017, he reported thoughts of suicide over the past few days which he had not experienced for a long time. His ex-partner had come to stay to provide support, and to safeguard his medications. The next day Mr de Wet reported that his ex-partner was no longer staying but had left him two days worth of medication and he had another friend coming over to support him.

[22] Dr Yip reported that he first became involved with Mr de Wet's care was on 17 March 2017 when Mr de Wet presented with a low mood, which had worsened in the previous week without an identified trigger. He reported his flatmate was unaware of his struggle and that the previous night his ex-partner had come to support him. Mr de Wet disclosed that he had suicidal thoughts and was thinking of overdosing. He told Dr Yip that following advice from the mental health crisis team when he made contact on Tuesday (14 March) he had increased his usual daily nortriptyline dose from three 25mg tablets at night to four 25mg tablets at night and had about a month's supply on hand at home. He reported he did not feel safe being alone at home by himself, that he had not had suicidal ideation for at least ten years and that he had previously overdosed many years ago. Dr Yip recorded that Mr de Wet demonstrated no formal thought disorder and had good insight in seeking help. Dr Yip contacted the mental health crisis team who confirmed Mr de Wet was already in their referral system as he had self-initiated contact with their service the previous day and that they would be in contact with him that evening. Dr Yip reported there was no immediate safety concern and Mr de Wet returned home where he had a supportive friend with a plan for follow-up by the crisis team later that day.

[23] When contacted by a SMHAS social worker on 20 March Mr de Wet requested further medical review. On 22 March Mr de Wet was reviewed by consultant psychiatrist

Dr Tom Krstic. Mr de Wet reported his belief that nortriptyline was no longer effective for him, having become sensitive and anxious over the last month, and having suicidal thoughts around two weeks before with concern that he might act on them. He had been unable to cope with work, which he identified as his main stressor, and had not attended for the last week. He reported asking his ex-partner to remove the nortriptyline from his house out of concern he might attempt to overdose on it. He disclosed having researched a fatal dosage. His ex-partner and current partner were living with him to provide him with support. Mr de Wet is reported to have told Dr Krstic that he did not ever want to try again to end his life, that he saw the impact his last attempt had had on friends and family, whom he identified as a strong protective factor. He requested to discontinue nortriptyline and go back to sertraline which had helped his mood for six years previously.

[24] After discussing medication options a decision was made to reduce and stop nortriptyline and restart sertraline, with close monitoring. As a tricyclic antidepressant nortriptyline is reported to be recognised as less safe in overdose than the SSRI sertraline. There was reported to be discussion about options to keep Mr de Wet safe including hospitalisation or respite however Mr de Wet reassured Dr Krstic that someone was with him all the time, he was currently safe, and his ex-partner had removed his nortriptyline. He agreed to arrange to see his therapist within the following fortnight.

[25] In telephone contact on each of the following four days Mr de Wet reported he was successfully cross-titrating his nortriptyline to sertraline and had no further suicidal ideation.

[26] On 27 March 2017 Mr de Wet was again reviewed by Dr Krstic who recorded that Mr de Wet's medication had been successfully changed from nortriptyline to sertraline although he had stopped nortriptyline "a little quicker than suggested". Mr de Wet's mood and anxiety levels were reported to be fluctuating, with severe anxiety experienced the previous day. He denied current suicidal thoughts, plan or intent and expressed a desire to return to work on 31 March. Dr Krstic's impression was that Mr de Wet's mental state was much the same, there were no clear imminent safety issues and it was recommended that Mr de Wet increase the sertraline dosage. Mr de Wet undertook to call his therapist.

[27] When contacted on 30 March Mr de Wet denied suicidal ideation, although had fleeting thoughts the day before. He said he would call the team if he felt unsafe as he had

done previously. On 2 April Mr de Wet reported being settled over recent days and felt thing were improving, he had not been anxious and was taking sertraline at the 100mg dose as prescribed. He denied any safety issues and stated he was feeling safe. SMHAS staff could not contact Mr de Wet on 5 April and he was subsequently spoken to on 6 April by RN McNulty. Mr de Wet was reported to be difficult to engage over the telephone but stated he was doing well and had returned to work which he was enjoying. He reported no problems with sertraline and his sleep, mood and anxiety had improved. He agreed to a medical review on 11 April.

[28] Further contact was made with Mr de Wet on 9 April and he reported no further concerns or safety issues. He confirmed his attendance for the medical review on 11 April. Mr de Wet failed to attend that review and could not be contacted until 12 April. He claimed to have slept through the appointment time. He reported his mood and energy levels were slowly picking up, he was eating regular meals, was sleeping more than usual, his concentration was variable. His reduced energy levels and oversleeping were identified as his main worries. Mr de Wet reported an improvement in suicidal ideations with minimal thoughts in the previous week; he denied any current plans or intent. He confirmed he had been taking 100mg dose of sertraline as prescribed but was to discuss at increase in dosage at his next medical review. He could not attend the following week due to work commitments but undertook to attend the week after. Efforts to contact him on 15, 16, 17 and 18 April to schedule the medical review appointment were unsuccessful. A letter was sent to him asking him to contact the SMHAS to schedule another medical review.

[29] Mr de Wet was contacted on 19 April 2017 by RN Costas. Mr de Wet stated he was still suffering very low energy although he felt his mood was picking up. He asked to reschedule his medical review. RN Costa suggested a face-to-face catch-up over the weekend. It was agreed he would be called on the morning of Saturday 22 April to arrange a face-to-face review with clinicians the next day.

[30] On 20 April 2017 Mr de Wet re-presented to Dr Yip with a cough and breathlessness requiring more frequent use of his inhaler. Dr Yip assessed that Mr de Wet had an exacerbation of his asthma, as evident by his diffuse wheeze and the absence of crepitation on auscultation of his chest. Mr de Wet was provided with a prescription for prednisone (a steroid) should he need it to ease his breathing. At that time, Mr de Wet did

not complain of any chest pain or discomfort. He told Dr Yip that the crisis team had continued to be in contact with him and that his mood had improved since his last visit. Dr Yip reported that the clinic did not receive any letters from the crisis team detailing the assessment and management of Mr de Wet.

[31] Dr Yip reported that pharmacy dispensing records showed that in addition to his regular medications Mr de Wet had been dispensed sertraline 50 mg tablets on 28 March 2017 and 100mg tablets on 30 April 2017, and quetiapine 25 mg tablets on 12 April 2017.

Events leading up to Mr de Wet's death

[32] Mr de Wet's ex-partner, Mr McNeilage de Wet, had moved back into Mr de Wet's home towards the end of March 2017 to provide Mr de Wet with support for his mental health. On 19 April 2017 Mr de Wet sent a text message to Mr McNeilage de Wet advising that he was feeling unwell and was not going to work that day. Later that night Mr de Wet appeared to Mr McNeilage de Wet to be better.

[33] On 20 April 2017 Mr de Wet sent a text message to Mr McNeilage de Wet and told him that he had slept most of the day and that he was feeling unwell, he reported feeling constricted in his chest which made it difficult for him to breathe. He described the feeling as a mixture of an anxiety attack and difficulty with breathing. Mr de Wet subsequently consulted with Dr Yip. Mr McNeilage de Wet reported that Mr de Wet was prescribed an inhaler but he did not fill the prescription that day. When Mr McNeilage de Wet got home he made Mr de Wet some dinner at around 6:00 pm. He reported that Mr de Wet appeared to him to be tired but in good spirits.

[34] Mr McNeilage de Wet told Police that at about 1:30am on 21 April 2017 he was awoken by a loud bang. He went to investigate the sound and found Mr de Wet crawling up the stairs in the house on his hands and knees. Mr de Wet said he had fallen forward but was fine. Mr McNeilage de Wet assisted Mr de Wet back to his bed.

[35] Mr McNeilage de Wet slept most of that day, waking at around 2:30pm. He noticed the dogs were not downstairs and went to Mr de Wet's bedroom looking for them. When he entered, he found Mr de Wet on the floor between his bed and bedside table. His impression was that Mr de Wet had slipped from his bed onto the floor. He was lying on his back and appeared to be convulsing. Mr de Wet had some level of consciousness and

appeared to settle when Mr McNeilage de Wet placed his hand on his chest and spoke to him. Mr McNeilage de Wet called emergency services at 3:12pm. Mr de Wet was transported to Waitakere Hospital where he was assessed in the ED.

[36] In a report for my inquiry, Dr Jonathan Casement, an ICU specialist at North Shore Hospital, detailed Mr de Wet's care and treatment at Waitakere Hospital and subsequently at North Shore Hospital. Mr de Wet was assessed in the Waitakere Hospital ED as having ongoing drowsiness (GCS<10), hypothermia, and abnormal ECG. The differential diagnosis for Mr de Wet's low conscious level included a possible head injury, an overdose of either sertraline or reducing dose of nortriptyline, or infection. Mr de Wet was commenced on various medications and fluids, and investigations involving blood cultures, chest x-ray and a brain CT were undertaken. On account of the number of potential diagnoses to be worked through it was decided that Mr de Wet would be transferred to North Shore Hospital ICU. Whilst still in the ED, Mr de Wet's level of consciousness dropped to a level requiring that he be intubated. Due to his history of past trauma during intubation, a fibre-optic inspection of his airway prior to intubation was required. Just prior to intubation Mr de Wet suffered a seizure which self-terminated after a few seconds. He was then successfully intubated and transported to North Shore Hospital ICU, arriving at 9:45 pm. Preliminary CT scan results indicated a CT angiogram (blood vessel study) for the following day. The overall impression was of reduced GCS without a definitive cause. The differential diagnosis recorded in the notes was of (i) possible low coma score following epileptic seizure due to community acquired pneumonia; (ii) tricyclic overdose; (iii) thrombosis in the basilar artery area of the brain.

[37] Overnight Mr de Wet was administered medications to treat a possible infection, reduce the risk of blood clots, and activated charcoal to try to reduce any further absorption of tricyclic antidepressants. The following morning Mr de Wet was drowsy but able to obey commands, and was stable from a cardio-respiratory point of view.

[38] A repeat ECG showed improvement, his cerebral function and neurological response had improved to the point where he was able to be extubated at around 10:00 am. He was given his regular anti-seizure medication and remained stable in ICU. At about 12 noon Mr de Wet was taken for a CT angiogram but just prior, in the CT room, he suffered a tonic clonic seizure of around 30 seconds duration. Following this his ECG showed coarse ventricular fibrillation, CPR, DC shocks, and intubation were commenced.

Despite the efforts of the medical staff Mr de Wet was confirmed to be deceased at 3:03pm.

Was Mr de Wet's death a self-inflicted death in circumstances amounting to suicide?

[39] In terms of the medical cause of Mr de Wet's death Dr Lamont assessed that "the picture is dominated by the natural disease" and in the context of the background events, considered the nortriptyline level to be of much less significance than he had initially determined. Dr Lamont's revised opinion is that Mr de Wet's death was due to a cardiac event secondary to myocardial ischaemia and narrowing of coronary arteries by atherosclerosis in association with high nortriptyline levels in the blood. As Dr Lamont identifies, the evidently high dosage of nortriptyline that was taken by Mr de Wet could be consistent with an effort to relieve the chest pain and breathing difficulties which Mr de Wet himself reportedly characterised as similar to a panic attack.

[40] While it is Dr Lamont's opinion that natural disease is the dominant feature of Mr de Wet's cause of death, the self-inflicted nortriptyline overdose is nevertheless considered to have potentially contributed at some level to exacerbate the natural disease that was present. As such, I must consider whether that self-inflicted medication overdose was an intentional act in circumstances amounting to suicide, or an accidental misjudgement in self-medicating.

[41] The evidence before my inquiry does not lend itself to a clear answer. On the one hand, Mr de Wet was a man with a significant history of depressive episodes and recent contact with the acute specialist mental health team in the weeks and months before his death with suicidal ideation and thoughts of overdosing having researched the fatal dosage of nortriptyline. On the other hand, Mr de Wet had attended his GP the previous day with difficulty breathing which was assessed to be exacerbation of asthma. He was prescribed an inhaler but did not fill the prescription. He had a known history of epilepsy that appeared well controlled and he had been seizure free for the preceding six years. He had successfully cross-titrated a change from nortriptyline to sertraline three-four weeks earlier as he reported side-effects and lack of therapeutic effect from nortriptyline. He described his symptoms the previous day as similar to a

panic attack. He had also previously demonstrated sufficient insight to engage with community mental health and seek support from those close to him when he was edging toward suicidal crisis.

[42] In weighing the competing evidence, I must place some weight on Mr McNeilage de Wet's evidence that on 20 April Mr de Wet described having a constricted chest in the nature of a mixture of an anxiety attack and difficulty breathing. Mr McNeilage de Wet's reported impression was that Mr de Wet had been in good spirits later that evening, with no indication that he was at imminent risk of self-harm. When asked by an ICU physician about the possibility of a nortriptyline overdose Mr McNeilage de Wet is reported to have expressed surprise and reported there had been no note or any evidence of final acts found.

[43] I must also have regard to the relevant legal test to be applied for establishing suicide. Suicide requires satisfaction of three elements: that the death is self-inflicted, that the person's actions were undertaken with the intention of taking their own life, and that the person knew death to be the probable consequence of their actions.[1]

[44] The standard of proof, or threshold that needs to be met before a Coroner can be satisfied that a fact or an element of the test has been proved, is the civil standard of balance of probabilities. A finding of suicide requires a degree of proof that is commensurate with the serious nature of such an allegation; the principle being that the graver the allegation, the clearer, more cogent and more exacting the evidence must be before the balance of probabilities evidential burden is met.[2]

[45] Accordingly, I must be satisfied that there is clear evidence from which I can infer that Mr de Wet acted in taking an overdose of medication with an intention to end his life, knowing the probable consequence of his actions. The fact that an accident is not established does not mean that suicide is established, and suicide must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be sufficiently proven to justify a serious finding of this nature.

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[1] *Re Sutherland (deceased)* [1994] 2 NZLR 242 (HC) at 250.
[2] See *Z v Dental Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1.

[46] In the final analysis of all of the evidence before my inquiry, I find that an overdose of nortriptyline was likely a contributing factor in Mr de Wet's death in that it exacerbated his underlying myocardial ischaemia and atherosclerosis, but that the evidence does not allow for a finding that the overdose of nortriptyline occurred in circumstances amounting to suicide.

Findings

[47] I find that Christiaan Rudolf de Wet died at North Shore Hospital, Auckland on 22 April 2017. The cause of his death was a cardiac event secondary to myocardial ischaemia and narrowing of coronary arteries by atherosclerosis in association with high nortriptyline levels in the blood.

Recommendations

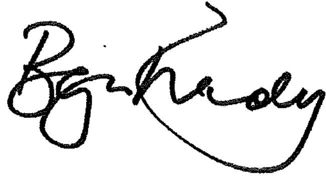
[48] Exceeding the prescribed dosage of medication to a potentially toxic level is readily and commonly understood by the public as having potentially adverse and even fatal outcomes. Less obvious to even a long-term medication user may be the risk an excessive dosage presents in terms of exacerbating underlying natural disease, and thereby causing death. As a tricyclic antidepressant nortriptyline is reported to be recognised as being less safe in overdose than the SSRI sertraline. Compliance with the prescribed dosage is therefore critical and medical input should be sought rather than resort to self-medicating in excess of the prescribed dosage. Given the nature of these observations, I do not consider that there are any formal recommendations required.

[49] A copy of this Finding will be sent to the Centre for Adverse Reactions Monitoring (CARM) for informational purposes.

Restrictions on publication

[50] Pursuant to section 74 of the Coroners Act 2006, I am satisfied it is in the interests of decency and personal privacy to prohibit the publication of photographs of Mr de Wet taken during the investigation into his death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

I extend my condolences to Mr de Wet's family and friends for their loss. I acknowledge and express regret for the significant time taken to conclude my inquiry and make Findings.



CORONER B WINDLEY