IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012 1388

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of CAROLINE COURTENAY WEBSTER

without holding an inquest:

find that the identity of the deceased was CAROLINE COURTENAY WEBSTER

born 18 June 1958

and the death occurred between 15 and 18 April 2012

at 6 Newham Grove, Ormond 3204

from:

1 (a) COMBINED DRUG TOXICITY (PROPRANOLOL AND INSULIN)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Caroline Courtenay Webster was 53 years of age at the time of her death. She lived at 6 Newham Grove, Ormond and had a medical history that included an essential tremor, smoking, depression and previous suicide attempts.

2. Ms Webster completed high school, held several other jobs, eventually commencing nurse training in 1983 and she remained in Melbourne when her family moved to Tasmania in the same year. Once she was qualified, Ms Webster worked as a Registered Nurse (RN) at Prince

Henrys Hospital and in 2000 worked in the Intensive Care Unit (ICU) at the Monash Medical Centre (MMC)[1] on nightshift.

3. In 2001, Ms Webster's family and friends noticed that she began displaying symptoms of anxiety and depression following the breakdown of a relationship. In the same year, she declared bankruptcy and developed a dependency on benzodiazepines

4. In 2002, Ms Webster started consulting General Practitioner (GP) Dr Peter Drake for management of anxiety, depression, and benzodiazepine dependency. In 2003, she consulted Private Psychiatrist Dr Lynette Chazan, and in 2004, Private Psychiatrist Dr Andrew Stockey.

5. In 2008, Ms Webster's Nursing registration was suspended. Her friends noticed a subsequent deterioration in her home hygiene and evidence of contining medication abuse.

6. In July 2010, Ms Webster's was treated at the Alfred Hospital following an overdose. Ms Webster stopped seeing Dr Stockey following a diagnostic disagreement and commenced consulting with Private Psychiatrist Dr Lev Botvinik in March 2011. Her prescribed medications were Propranolol[2] 10mgs, Lithium slow release,[3] Escitalopram, Lamotrigine,[4] Agomelatine, Zolpidem, Quetiapine. Dr Botvinik diagnosed treatment resistant major depressive disorder with some anxiety.

7. In 2011, Ms Webster took an overdose of Propranolol whilst at work at MMC. Dr Botvinik provided follow-up care and suggested decreasing her use of Zolpidem and Quetiapine, however Ms Webster was reluctant. In September 2011, Ms Webster took what appeared to be an accidental overdose of Propranolol.

8. Ms Webster last consulted with Dr Botvinik on 6 March 2012, when she identified a number of stressors, including financial stressors and a decreasing ability to self-care. Dr Botvinik

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[1] Part of Monash Health, or as it was referred to at the time of Ms Webster's death, Southern Health.

[2] Propranolol, a beta-blocker. The product information sheet states it is used to treat hypertension and cardiac dysrhythmias (abnormal heart rhythms), to prevent angina, to treat or prevent heart attacks, reduce risk of heart problems following a heart attack, to treat irregularities in heart beat, including those caused by anxiety, essential tremor (shaking of head, chin, hands), phaeochromocytoma (tumour of adrenal gland tissue), Fallot's Tetralogy (congenital heart defect) or to prevent migraine headaches.

[3] Lithium, (Lithcarb/Quilonum SR) is used to both treat and prevent episodes of bipolar disorder, in which there are sustained mood swings either up (manic) or down (depression). It is also used in the treatment of schizo-affective illnesses.

[4] Escitalopram (Lexapro) is a selective serotonin reuptake inhibitor/ antidepressant for moderate to severe generalised anxiety disorder and moderate to severe social anxiety disorder and depression.

suggested that Ms Webster be referred to a sleep physician regarding insomnia and her dependency on Zolpidem, however she refused.

9. On 12 March 2012, Ms Webster worked her last shift at MMC and had her last consultation with Dr Chazan.

10. On 13 March 2012, Ms Webster attended Ormond Medical Centre, and consulted with GP Dr James Lichtblau. She was prescribed Zolpidem, Nitrazepam, and Prothiaden.

11. On 15 March 2012, Ms Webster's friend Ms Cheryl Jacka took her to see GP Dr Sally Blombery at the Jasper Family Medical Practice after Ms Webster had sustained burns to her face, arms, and hands from an oil fire in her kitchen two days prior for which she had not sought treatment. Dr Blombery informed Ms Webster that if she did not attend MMC, she would arrange for a Crisis Assessment and Triage (CAT) Team assessment. Ms Jacka observed that Ms Webster was manipulative with Doctors and that her behaviour had become erratic after learning that Ms Jacka would be moving to Ocean Grove, which Ms Webster had expressed she was unhappy about. Ms Jacka later telephoned Dr Michael Stagg and explained her concerns regarding Ms Webster and that she suspected Ms Webster of doctor shopping. Ms Webster's neighbours had also contacted Victoria Police after she exhibited erratic behaviours and was slurring her words. Ms Webster was treated at the MMC ED. She was assessed by ED medical staff and Emergency CAT Team (ECATT) as calm, settled, had no psychotic symptoms, and when questioned, stated she had stopped taking extra medications and did not abuse any substances. Ms Webster requested a script for Zolpidem, which was refused. An appointment for a plastic surgery review to treat her burn injuries was arranged for the following day however, she failed to attend.

12. On 16 March 2012, Ms Jacka informed Dr Kay Hurwitz at Jasper Family Medical Centre of Ms Webster's doctor shopping, and the visit by Victoria Police. Dr Hurwitz contacted Victoria Police to confirm the visit. Dr Hurwitz then spoke with Dr Lambros of MMC regarding the assessment, and Dr Stagg notified MMC ICU Nurse Unit Manager (NUM) Dennis Fenlon that Ms Webster may be unfit for duties and that notification to the Nurses Board would be made. According to the health records, NUM Fenlon stated Ms Webster was currently the subject of performance review.

13. At 3.16pm on 16 March 2012, Dr Blombery made a referral to The Alfred CAT Team after trying to locate Ms Webster. At 8.15pm, an Alfred CAT Team Triage clinician telephoned Ms

Webster, who minimised her medication regime and denied having been prescribed any medication from anyone aside from Dr Botvinik. When challenged about the monthly long-term scripts she had received from Ormond Medical Centre, she denied Doctor Shopping. The Triage clinician documented concern relating to Ms Webster's ongoing employment as an RN in an ICU. At 8.30pm, the Triage clinican spoke with Ms Jacka, who reported Ms Webster was behaving in a more 'elevated'[5] way. She described Ms Webster's history of alcohol abuse, 15-year history of prescription pill dependency, and recent change in Private Psychiatrist to Dr Chazan because of Ms Webster's disagreement with a BPD[6] diagnosis. A CAT Team home assessment was arranged for 17 March 2012. Doctor shopping alerts were set by The Alfred Psychiatry, Ormond Medical Centre and Jasper Family Medical Centre.

14. On 17 March 2012, two CAT Team clinicians visited Ms Webster at home, and then contacted Dr Peter Drake at the Jasper Family Medical Practice with a plan for follow up with Ms Webster. Ms Webster was assessed as having impaired judgement with poor functioning and difficulties with activities of daily living, but she was not assessed as psychotic. She presented as alert, denied substance abuse, and blamed Quetiapine for the sedation and increase in accidents her family and friends were noticing. Ms Maryanne Furst (Ms Webster's sister from Tasmania) contacted a CAT Team clinician to report they had noted a decline in functioning and mood since their mother died two years prior, that she was ringing family at different hours with slurred speech but clarified that the state of her home was not unusual.

15. On 22 March 2012, Dr Blombery contacted the Alfred CAT Team after unsuccessful attempts at contacting Ms Webster. The CAT Team contacted Psychiatrist Dr Corrine Haber (covering Dr Botvinik's leave) and two CAT Team clinicians conducted a home visit. Ms Webster presented as confused and unsteady but blamed Quetiapine (ceased 8 months earlier) for her presentation. She also claimed to have been taken off Zolpidem a year prior (despite evidence to the contrary). The CAT Team recommended she no longer use Quetiapine and that she see Dr Drake. Her burns were noted to be healing and Ms Webster spoke of a planned return to work. Ms Webster denied taking several medications she was later determined to be taking, and denied alcohol and benzodiazepine abuse. Both Dr Drake and Dr Botvinik were notified of the outcome of the assessment.

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[5] A state of mind that shows some indicators of mania, or hypomania, for example when a person is too happy, animated, spending money, grandiose.

[6] Borderline Personality Disorder.

16. On 28 March 2012, Dr Drake contacted Ms Webster to arrange a review appointment on 13 April 2012 and to offer a sick certificate for work at MMC, who were happy to place her on sick leave. Ms Webster stated she was well and that her burns were healing.

17. Ms Webster cancelled her appointment with Dr Botvinik for 10 April 2012. Dr Botvinik contacted Ms Webster regarding her non-attendance and she stated she was well. Dr Botvinik spoke with Dr Chazan who stated Ms Webster had cancelled her previous three appointments. They discussed a referral to Australian Practitioner Health Regulation Agency (APHRA) and to VicRoads in light of the increase in substance abuse after ascertaining Ms Webster was also obtaining Zolpidem from Dr Drake. A plan was developed to make a CAT Team referral if Ms Webster failed to attend her next appointment, which she did on 13 April 2012 (Dr Drake) and 17 April 2012 (Dr Chazan).

18. On 18 April 2012, Dr Botvinik unsuccessfully attempted to contact Ms Webster three times and contacted Dr Drake and Dr Chazan. A decision was made to make a CAT Team referral should further attempts at contact fail.

19. On the same day, Ms Nicky Bean, Ms Webster's longstanding friend and colleague, received an express-post letter from Ms Webster containing a note stating she had taken an overdose, giving directions to have her animals 'put down' and providing the contact number for Victoria Police. Ms Bean contacted the Caulfield Police Station and at 4.28pm, Victoria Police located Ms Webster deceased in her home. Ms Webster had left a note for her sister Ms Furst and information regarding her doctors and pets. Police located used and unused syringes, 2 empty vials of Actrapid (insulin) and multiple medication blister packets, the majority being empty.

INVESTIGATIONS

20. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Ms Webster, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Examinations failed to reveal any significant results.

21. Toxicological analysis of blood retrieved post mortem identified the presence of Propranolol[7] and a markedly raised insulin level. Dr Burke noted that whilst this lends support to a hypoglycaemic state post insulin overdose, it is not in itself diagnostic, as a negative glucose may be seen as a post mortem artefact. Dr Burke ascribed the cause of Ms Webster's death to combined drug toxicity (Propranolol and insulin).

22. The circumstances of Ms Webster's death have been the subject of investigation by Victoria Police. The Police investigation did not identify evidence of third party involvement.

23. Police obtained statements from Ms Webster's friends and Dr Drake.

CPU Review

24. The Coroners Prevention Unit (CPU)[8] were requested to review the treatment and management of Ms Webster on behalf of the Coroner. In particular, Mr Webster's longstanding mental illness, clinical deterioration and the involvement of private practitioners and the CAT Team required further enquiries.

Doctor shopping/drug abuse

25. As a trained nurse, Ms Webster would have had a reasonable level of knowledge about the medications she was taking to be able to explain any symptoms of sedation and confusion that appeared to be related to her abuse of Zolpidem. For example, being able to blame Quetiapine for her sedation to the CAT Team when in fact she had stopped taking this medication eight months prior. The many doctors she engaged with were never clear of what she was taking as it was apparent she was seeking drugs, especially sleeping tablets and ultimately Zolpidem from at least *eight* prescribers and having the scripts filled at a minimum of three pharmacies. The

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[7] Is a beta-adrenergic blocking agent commonly used for the treatment of high blood pressure, cardiac arrhythmias, irregularities in heartbeat associated with anxiety, essential tremor and to prevent migraine headaches. The therapeutic plasma concentration is 0.05 – 1.0mg/L. Steady state plasma concentrations following daily therapy of 80mg and 320mg have been reported as 0.02 and 0.34mg/L, respectively .Life threatening toxicity included hypotension, congestive heart failure and bronchospasm. It acts as a depressant of the central nervous system. The detected blood concentration was reported as 3.1mg/L.

[8] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Medicare and Pharmaceutical Benefits Reports (PBS) have assisted in identifying the multiple prescribers and pharmacies Ms Webster was seeking and obtaining medications from, however theses reports are not necessarily exhaustive. It remains uncertain whether these identified practitioners where the only medication sources as the Medicare/PBS reports do not record private scripts.

Communication between services

26. When any of the prescribers (for example Dr Botvinik, Dr Chasen and the Alfred CAT Team) became aware of multiple people involved in Ms Webster's care, there was proactive and appropriate communication with clear care plans and contingency plans should Ms Webster continue to avoid her appointments. The communication and shared decision making between the practitioners in the Jasper Family Medical Clinic was comprehensive and proactively engaged with MMC, friend Ms Jacka and Ms Webster's family to inform of their decision-making. The communication between Drs Botvinik, Chasen and the practitioners in the Jasper Family Medical Clinic once they identified problems was also appropriate and responsive. The communication and alert setting between the Jasper Family Medical Centre and the Ormond Road Clinic once the doctor shopping was identified was appropriate and timely.

27. The prescribing and dispensing records suggest Ms Webster had reengaged in abusing sedatives, especially Zolpidem, since April 2011 and managed to continue to work at MMC until she was experiencing periods of erratic behaviour and poor judgement when directly under their influence. However, Ms Webster remained able to present well when not under their influence, continuing to work until 12 March 2012. Ms Webster had been dishonest to her family and friends regarding her welfare, her use of drugs and alcohol, her capacity to work, her diagnoses, and medical treatment plans. This allowed her to decrease her engagement at will and increase it with whatever prescriber she considered would meet her needs regarding prescribing medications, especially Zolpidem.

Zolpidem dependency

28. Zolpidem is a short acting sedative drug, which is used as a sleeping tablet. It is dispensed solely on prescription and is recommended for short-term use only. It is quick acting with a short duration of action of only a few hours and no residual sedation or hangover effect the following day. There is evidence of bizarre behaviours such as watching television, using the telephone, going to places and driving a car following use of Zolpidem. Zolpidem was

originally considered as not having the potential for abuse and dependency however, there is evidence of dependency developing in some patients.[9] Based on the available information, it is probable the Ms Webster had developed a dependency to Zolpidem.

29. Ms Webster had accessed scripts for Zolpidem from eight prescribers across four separate medical clinics during the 12 months prior to her death, close to one script per week. In addition, she obtained a number of scripts for the hypnotics Nitrazepam and Temazepam. The Medicare and PBS report did not have a record of any scripts for Ms Webster for Zolpidem, Nitrazepam, and Temazepam, nor did the dispensing records from the pharmacies identified; therefore it is probable that all of these scripts were private. It is consequently unknown if Ms Webster consulted with any other prescribers or obtained further medications from unidentified pharmacies. The only evidence of Zolpidem at the scene of her death was an empty sheath.

Propranolol access

30. Ms Webster was prescribed Propranolol for an essential tremor by Dr Peter Drake, the last recorded prescription being on 15 September 2011. There is no record of it having been dispensed in the records obtained from three pharmacies reviewed. It was prescribed as a 10mg tablet, 100 tablets with five repeats, with directions to take it three times a day when required.

31. In 2013 the CPU reviewed overdose deaths involving Propranolol in Victoria between 2000 and 2012:

    The CPU identified 53 overdose deaths involving Propranolol that were investigated by Victorian Coroners because 2000 and 2012. The CPU analysed these deaths and reported a range of findings including:

    a. the annual frequency of deaths did not vary markedly from year to year.

    b. approximately 75% of deaths were of females.

    c. the majority of deaths were from combined drug toxicity (90.6%); the most frequent co-contributing drugs were antidepressants and benzodiazepines.

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9 Hajak, G, Müller, W, Wittchen, H et al, 1998. Abuse and dependence potential for the non-benzodiazepine hypnotics zolpidem and zopiclone: a review of case reports and epidemiological data. Addiction, 98, 1371–1378; Jana, A, Arora, M, Khess, R et al, 2008 A Case of Zolpidem Dependence Successfully Detoxified with Clonazepam. The American Journal on Addictions, 17: 343–344, 2008; Keuroghlian, A, Barry, A, & Weiss, R, 2012. Circadian Dysregulation, Zolpidem Dependence, and Withdrawal Seizure in a Resident Physician Performing Shift Work. The American Journal on Addictions, 21: 576–577.

d. the Propranolol involved in the fatal incident was usually prescribed to the deceased to treat one or more of a range of conditions.

e. in the majority of cases, the deceased intentionally overdosed.[10]

32. The 2013 review recognises that the involvement of Propranolol in suicidal activity has been previously identified and potential dangers when prescribing Propranolol to patients as risk of self-harm have been highlighted. A warning or precaution of this type is currently not found in the standard Australian information resources on Propranolol prescribing, particularly in the MIMS Full Prescribing Information and the Australian Medicines Handbook.

COMMENTS

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

Ms Webster's decision to suicide by overdose does not appear to have been impulsive. The degree of planning and coordinating to leave detailed instructions for her friend to carry out after her death, to write the letter and calculate the time it would take for the postage to reach her friend and ensure her cats had access to sufficient quantities of food suggests that she diligently formulated a plan prior to taking her own life. In addition, the decision to use a combination of insulin (Actrapid Insulin and syringes found at the scene) and Propranolol, both drugs lethal in overdose alone, suggests Ms Webster had considered the mechanism of her death. The Propranolol was prescribed by Dr Peter Drake for an essential tremor, however, Ms Webster had not been diagnosed with insulin dependent diabetes mellitus and it is therefore probable that she accessed the Actrapid Insulin and syringes at her workplace.

A real-time prescription monitoring system would have influenced the duration of prescribers being unaware of Ms Webster's doctor shopping practices, and I refer to and repeat my Recommendations made in the matter of Mr Kirk Ardern (COR 2012 2254)[11] in this respect.

In a previous coronial matter, Coroner Spanos addressed issues of storage and access to insulin in Victoria.[12] A CPU review of Victorian deaths investigated by Coroners between 2000 and 2011 identified six intentional deaths where insulin was present. Of these deaths, five were identified

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10 Page 14.

[11] Available at http://www.coronerscourt.vic.gov.au/.

[12] Investigation into the death of Anne PePe, COR 2009 3896.

where the Coroner determined that insulin was the sole drug contributing to death. In two of the six deaths, there is evidence that the deceased obtained insulin from their place of work. In one further death, it is possible that the deceased obtained the insulin from their place of work.

The Society of Hospital Pharmacists of Australia (SHPA) provided a statement in March 2012 regarding differences in the appropriate and safe storage of and access to insulin in hospitals in other Australian States when compared to Victoria.[13] Along with Tasmania and New South Wales, Victoria has the most stringent storage requirements for prescription-only medicines in Australia. Insulin, being a prescription only/restricted drug/Schedule 4 poison,[14] mandates that it must be stored in a lockable storage facility to prevent access by unauthorised persons at all times. Insulin specifically requires refrigeration and therefore requires storage in a lockable refrigerator.

Under Victorian Legislation, only an authorised person may be in possession of the key to the locked storage facility. In hospitals, authorised persons include nurses.

Insulin's status as a high-risk medication relates to the fact that it can cause serious harm if the incorrect dose is administered and has been implicated in critical incidents where there have been prescribing or administration errors. The SHPA advised that critical incidents involving insulin are generally not related to its storage or accessibility and that insulin is required to be available in almost every patient-care area of an acute hospital.

The SHPA suggested that insulin is only one of many Schedule 4 medicines that could be misused, and that it was be impractical, in the absence of fully integrated electronic medicines management systems, to require recording and verification of every dose of all medicines that have the potential for misuse when considering the volume of Schedule 4 poisons used in hospitals. The SHPA suggested the in busy hospitals where patient care requires that drugs are readily accessible, a balance must be achieved between the security of drugs, the accessibility of drugs and the accountability of health care professionals for complying with laws, policies and procedures governing the secure storage and administration of drugs.

Ms Webster's friends, Ms Cheryl Jacka and Ms Nicky Bean, and her sister Ms Maryanne Furst provided care and encouragement to decrease her use of medications, to engage with services and were proactive in informing her treating practitioners of the actual events, which Ms Webster was apt at concealing.

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[13] Legislation in other jurisdictions such as Queensland and the Australian Capital Territory (as of March 2012) simply requires that these medicines be kept in an area to which the public do not have access.

[14] Schedule 4 within the Standard for the Uniform Scheduling of Medicines and Poisons.

There were no issues identified regarding quality of the care received by Ms Webster from any of her known medical service providers.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

The Therapeutic Goods Administration (TGA) is the main conduit through which prescribing precautions are disseminated and incorporated into standard Australian prescribing references. I **recommend** that the TGA consider issuing an alert to prescribers and advise exercising caution when prescribing Propranolol to patients at risk of self-harm, particularly self-harm by overdose.

Possible countermeasures for prescribers could include:

a. if clinically appropriate, a beta-blocker that is safer in overdose could be substituted for Propranolol.

b. scripts could be provided for small quantities of Propranolol, to reduce the amount of Propranolol to which the patient has access at once.

The reasoning behind above point b. is that at present, Propranolol packets contain 100 tablets, and up to five repeats can be included in a single script, providing patients access to up to 600 Propranolol tablets at once – that is, a sufficient quantity for an overdose. For patients who are at risk of self-harm by overdose, providing a script for 50 or 20 tablets at a time with no repeats would inhibit the patient's ability to access fatally large quantities of Propranolol at one time.

FINDINGS

The many possible precipitating factors that might have influenced Ms Webster to pursue the course of action she ultimately adopted were the prospect of the humiliation of a repeat nursing registration review, financial stressors, the loss of her sources of Zolpidem prescribers as clinics became aware of her doctor shopping and the fear of more intensive Psychiatric care.

The services involved responded appropriately in the first instance and increasingly so once practitioners knew Ms Webster's dependency and behaviours were of concern. At no time did any of the practitioners, in light of the comprehensive assessments completed, assess Ms Webster as meeting the requirements for the *Mental Health Act 1986* (Vic) for involuntary Psychiatric admission. Even when under the influence of sedatives, she would not have complied with an admission once the effects had resolved. The involved practitioners' efforts to engage Ms Webster

in therapy to address the issues leading to her dependency on Zolpidem were reasonable and offered Ms Webster several pathways to treatment, which she chose not to pursue. I accordingly make no adverse findings in relation to the health care practitioners involved in Ms Webster's care.

I accept and adopt the medical cause of death as identified by Dr Michael Burke and **find** that Ms Caroline Courtenay Webster died from combined drug toxicity (Propranolol and insulin) in circumstances where I am satisfied that she intended to take her own life.

I acknowledge the extensive research and synthesis of data performed by the Coroners Prevention Unit.

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

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

Ms Lucy Webster

Mr Michael Briant on behalf of the estate of Ms Caroline Webster

Ms Nicky Bean

Therapeutic Goods Administration

Monash Health

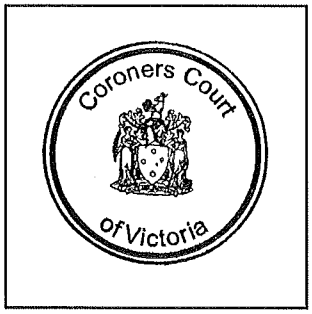
Alfred Health

Jasper Road Medical Clinic

Ormond Medical Centre

Constable R Menara

Signature:



AUDREY JAMIESON
CORONER
Date: **27 June 2014**