IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002501

FINDING INTO DEATH WITHOUT INQUEST - *REDACTED*

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**KD**
Date of birth:	1 June 1957
Date of death:	16 May 2014
Cause of death:	1(a) ASPIRATION OF GASTRIC CONTENT 1(b) COMBINED DRUG TOXICITY
Place of death:	Ivanhoe, Victoria

HER HONOUR:

Background

1. KD was born on 1 June 1957. He was 56 years old when he died as a consequence of the toxic effect of a combination of drugs.

2. KD is survived by his wife A and their twin 13 year old boys.

3. KD qualified as a doctor in 1980 in Tasmania and commenced medical practice there. He was de-registered due to a pethidine addiction shortly after he commenced practising. He moved to Melbourne in 1991 and studied pathology. He re-registered as a doctor in Melbourne in 1995, but after being found guilty of offences relating to prescription forgery he was de-registered for a second time on 3 June 2004.[1]

4. At the time of his death KD remained de-registered and worked as a lecturer in pathology. He was a frail man who suffered various health issues, including chronic iron deficiency anaemia, diverticulitis, bowel obstructions, hernia, anxiety and depression, and a chronic addiction to prescription medication.

The coronial investigation

5. KD's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

6. The role of a coroner is to independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

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[1] Conditions were imposed on his medical registration by the Medical Practitioners Board of Victoria in 2003, before he was ultimately de-registered the following year. His criminal record discloses subsequent instances of prescription forgery and drug-seeking which continued until 2010.

[2] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into KD's death. The Coroner's Investigator conducted inquiries on my behalf,

10. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

11. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

12. According to A's statement, in 2001, when KD's twin boys were born, *'things started to fall apart'* for him. He was admitted to the Melbourne Clinic for pethidine addiction treatment. He continued to use pethidine while at the Melbourne Clinic and consequently was admitted to a secure psychiatric ward at the Austin Hospital. He commenced taking anti-depressant and anti-psychotic medication. During 2002 KD was admitted to the Warburton Rehabilitation Centre for a short period for addiction treatment. During 2003 and 2004 KD attended the Ford Street Rehabilitation Centre in Ivanhoe.

13. In 2005, KD took an overdose of liquid morphine and was admitted to North Park Private Hospital in Bundoora. Whilst there he took a further dose of liquid morphine and consequently was admitted to either Box Hill or the Austin Hospital.

14. Not long after this KD was admitted to the Melbourne Clinic for treatment and began seeing an addiction specialist in Burwood.

15. Commencing in 2006 KD suffered chronic anaemia which required frequent hospitalisation. He also suffered a hiatus hernia which was repaired in 2007 at the Epworth Hospital. He regularly suffered pneumonia due to gastric reflux.

16. In early 2008, KD had a coronary stent inserted. Later that year he suffered a bipolar episode. He was taken to the Austin Hospital in a manic state, and was later discharged and transferred to North Park Private Hospital. From there he was admitted to the Austin Health secure psychiatric ward for approximately 2 or 3 months. During this admission he commenced taking quetiapine and saw a psychiatrist regularly.

17. Between 2010 and 2014 KD was in and out of hospital for bowel obstructions and/or bowel surgery. In April 2014, he had an incisional hernia repaired at the Epworth Eastern Hospital.

18. In early 2014 KD's brother P contacted the police alleging that he and his brothers suffered child abuse while attending a Catholic boarding school in Tasmania. According to A, KD was upset that P did this without consulting him and it *'unlocked some bad memories'*. In the days before his death A observed KD to be *'very drowsy on and off'*. He did not want to socialise or go to work and had no motivation.

19. On 15 May 2014, A telephoned KD to say she would be late home. She reported that he *'sounded funny'*. At 7.15pm she arrived home and thought KD *'looked shocking'*. He was running a bath. A had to collect one of their sons so she asked the other son to watch KD. She returned home at 8.15pm. KD was still in the bath and it appeared that he had vomited. When questioned he denied taking anything.

20. KD got dressed and sat on the end of the bed. He started to cough and remarked that *'every day is a struggle'*. From previous experience A thought he was coughing due to asthma. She asked whether she should take him to hospital or call an ambulance, but he assured her he would be alright and got into bed at about 9.30pm. A went to bed not long after.

21. A awoke at 4.45am and as usual placed her arm over KD's chest. She noticed he was not breathing and it appeared that he had vomited again. She attempted to resuscitate him and called an ambulance, but he could not be revived.

22. After KD's death, a packet of 100mg quetiapine tablets was found among his clothes by A. The script for the tablets was filled the preceding day (15 May 2014) and there were only 20 tablets left in a pack of 90. Inside the pack was a script for multiple repeats. The scripts were filled on 17 March 2014, 28 March 2014, 4 April 2014, 21 April 2014, 4 May 2014 and 15 May 2014. Each script was intended to last 30 days. A also later located in her husband's study rubbish bin a sleeve of Panafen Plus with 14 tablets missing, and a sleeve of Rafen Plus with 10 tablets missing.

Identity of the deceased

23. KD was visually identified by his wife A on 16 May 2014. Identity was not in issue and required no further investigation.

Medical cause of death

24. On 22 May 2014, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of KD after reviewing a post mortem CT scan. The autopsy revealed patchy myocardial fibrosis, a stent within KD's coronary artery, patchy to confluent bronchopneumonia (aspiration pneumonia) and bronchiolitis, and acute splenitis.

25. Toxicological analysis of post mortem blood specimens taken from KD identified the presence of codeine, morphine (likely as a metabolite of codeine), quetiapine, diazepam and its metabolite, temazepam and oxazepam (likely as a metabolite of temazepam), and ibuprofen. Ibuprofen, quetiapine and codeine were also detected in the stomach. The codeine and quetiapine levels detected were above normally observed therapeutic levels.

26. After reviewing toxicology results, Dr Dodd completed a report, dated 13 August 2014, in which he formulated the cause of death as '1(a) aspiration of gastric content; 1(b) combined drug toxicity'. Dr Dodd noted that the levels of medication were consistent with excessive and potentially fatal use. I accept Dr Dodd's opinion as to the medical cause of death.

Source of the pharmaceutical drugs taken by KD

<u>Benzodiazepines and quetiapine</u>

27. In 2008, KD commenced treatment under psychiatrist Dr Simon Croke for a psychotic illness and was prescribed quetiapine. Dr Croke stated that the quetiapine was '*gradually reduced and was down to 75mg at the last contact, with the expectation of ceasing in the following month or two*'. He also stated that KD had abused prescribed diazepam on '*at least two occasions*' and in late 2010 and early 2011 was undergoing a '*supervised reduction regime of diazepam which ended in February 2011*'. Dr Croke last saw KD in November 2011. Dr Croke explained that '*[t[he ending of contact was not planned, KD simply failed to return*'.

28. KD saw two general practitioners (**GPs**) at Clinic X. Dr B was KD's primary GP at that practice. He saw KD sporadically between 2005 and May 2009 (when his '*regular doctor was not available*') and then on a regular basis until their last consultation on 22 April 2014. Dr H was KD's secondary GP. Dr H worked at the clinic as a long term locum from January 2012. He saw KD when Dr B was unavailable. Between 22 March 2013 and 8 May 2014 KD saw Dr H on 8 occasions.

29. Dr B and Dr H prescribed a combination of two benzodiazepines to KD, namely diazepam and temazepam, over an extended period of time. In the six months before KD's death, he was prescribed two tablets twice daily of diazepam (four tablets per day) and 1 tablet of temazepam nightly.

30. Both Dr B and Dr H also prescribed quetiapine to KD. In the six months before KD's death, he was prescribed (mostly by Dr H) 100mg tablets of quetiapine (three tablets per night). Over a six month period, he ought to have been dispensed 540 tablets according to this prescription, however Pharmaceutical Benefits Scheme (**PBS**) records show he was dispensed 1800 tablets. Dr H's explanation for this excessive prescribing was that on each of the occasions he supplied KD with a prescription for quetiapine 90 tablets, intended to be 1 month's supply, he unintentionally supplied 5 repeats as this was the default setting for the practice software 'Medical Director Clinical' (this has now been changed). According to dispensing records, KD had the prescription and 5 repeats dispensed on 17 March 2014, 28 March 2014, 4 April 2014, 21 April 2014, 4 May 2014 and 15 May 2014 across five different pharmacies. Only two of those repeats were filled at the same pharmacy, almost two months apart.

31. Multiple statements were sought from Dr B and Dr H in relation to their treatment of KD and in particular their prescribing of the combination of diazepam and temazepam, and quetiapine over such a long period of time.[3]

32. According to Dr B, KD was already taking diazepam, temazepam and quetiapine when he began treating him regularly in 2008. He understood that the quetiapine was originally prescribed for a psychotic episode and then to treat anxiety as a result of opioid withdrawal. Dr B *'continued'* the treatment *'initiated'* by Dr Croke.

33. Dr B was aware that KD struggled with drug dependence, however he reported that KD's consumption of diazepam, temazepam and quetiapine showed no overall pattern of escalating usage. In particular, he helped KD reduce his intake of diazepam from more than 10 tablets per day to a *'stable'* dose of 4 tablets per day, his temazepam was stable at 1-2 tablets of per night (for insomnia) and his usual quetiapine dose was 100mg daily with occasional periods of increased dosage depending on need. In June 2012 KD reported that Dr Croke had adjusted his quetiapine dose to 200mg and it remained at that level until October 2013. Dr B understood the rationale behind using temazepam and diazepam together was that temazepam at night could assist in minimising the overall use of diazepam.

34. Dr B believed KD was receiving psychiatric care throughout the period of treatment and did not consider that further psychiatric evaluation was necessary. He did not contact Dr Croke because he did not have sufficient concern with KD's clinical presentation. In particular, he did not contact Dr Croke in June 2012 because it was not Dr B's normal practice to confirm specialists' adjustments to patients' medication. Normally, Dr B would only contact a specialist if there was an unexplained deterioration in the patient's condition or if there was a significant alteration to the treatment, particularly prescribed drugs. Dr B stated that he had *'no reason'* to believe KD was ever dishonest with him. His last consultation with KD occurred on 22 April 2014. At this consultation Dr B noted KD had recently undergone surgery and issued scripts for oxycodone hydrochloride (endone), diazepam and temazepam.

35. Dr H prescribed KD 5mg of diazepam in doses of 2 tablets '*as required*', and 2 temazepam tablets at night. He generally prescribed 100mg quetiapine daily, however the medical

[3] Dr H provided three 'statements' dated 18 December 2014, 28 July 2015 and 14 October 2016 (the latter two in the form of letters from his lawyers, Avant). Dr B provided three statements dated (or received) on 5 January 2015, 21 July 2015 and 23 September 2016. The first statements of each practitioner formed part of the coronial brief. The second and third statements were in response to enquiries from the Coroners Prevention Unit on my behalf.

records reveal that Dr H increased KD's daily dose of quetiapine from 100mg daily (on 5 December 2013) to 200mg daily (on 2 January 2014) then to 300mg daily (on 13 March 2014). When questioned about these increases, Dr H recalled that KD self-increased his dose of quetiapine due to a temporary increase in stress. Dr H stated that the increases were not a result of a clinical decision, but he did not think the dose increases were unreasonable. Dr H knew that KD had not seen Dr Croke *'in recent years'*, but saw no issue with this because KD was in a stable condition so did not require ongoing psychiatric review. He stated that he prescribed the treatment regime based on his belief that it had been *'established by Dr Croke and...[it] was working to keep the patient's condition stable'*. He believed that the regime was *'clinically indicated for a patient in a stable post-psychotic state'*. KD's use of diazepam, temazepam and quetiapine was, according to Dr H, *'stable and essentially unchanging'*. Dr H stated he would not normally expect to receive any communication from a specialist regarding a patient who is stable in treatment, but in any case he was aware that KD was no longer seeing Dr Croke. He believed the most appropriate approach was to continue the medication regime implemented by Dr Croke and maintained by Dr B. He never made any attempt to contact Dr Croke because he did not believe there was a therapeutic need to do so.

36. Dr B and Dr H both adopted a prescribing regime they believed had been initiated by Dr Croke. Dr B continued the regime on the false assumption that Dr Croke was providing clinical oversight when in fact Dr Croke had not seen KD since November 2011 and in any event never intended to establish a continuing medication regime. It is possible that KD deliberately gave the impression that Dr Croke was still involved to justify his extended use of benzodiazepines, and increased quetiapine dosages from time to time. This is supported by the comment in Dr B's second statement that: *'[f]or example, on 18 June 2012 KD reported that as a result of some variability in his mood his psychiatrist had increased the Quetiapine dose to 200mg daily'*.

Codeine, morphine and ibuprofen

37. Dr B recorded in July 2009 that KD reported that he had become dependent on a codeine paracetamol combination medication. There is no evidence in PBS records of KD being dispensed any codeine combination medication in the lead up to his death. This fact and the finding of the Panafen Plus and Rafen Plus sleeves in KD's study make it likely these over

the counter medications were the source of the codeine, morphine (as a metabolite) and ibuprofen in KD's system at the time of his death.

38. Both doctors were aware of KD's issues with opioid and benzodiazepine dependency. Dr B's justification for not notifying Drugs and Poisons Regulation was: *'Given KD's past history, the nature of his earlier issues with opioids, and my belief about the level of care/support he was already receiving I assumed he had already been reported to Drugs & Poisons as a drug dependent patient'*.

39. Neither doctor thought KD was at risk of suicide in the months before his death. Dr H's notes record that KD discussed a future holiday with his family in a consultation on 1 May 2014, shortly before his death. Neither doctor formed an impression that KD was engaging in drug-seeking behaviour, or suffering deterioration in his mental health, during his period of treatment at Clinic X.

KD's intention

40. A number of circumstantial factors support a finding that KD intentionally took an overdose of medication on 15 May 2014. He suffered from anxiety and was deeply upset when his brother made his statement to the police in early 2014 alleging child abuse. Further, the concentrations of drugs detected in KD's post-mortem samples were higher than expected for therapeutic use and it appears KD may have taken as many as 70 100 mg tablets of quetiapine in the 24 hours before his death. Finally, the fact he told his wife that *'every day is a struggle'* on the night of his death may indicate suicidal intent.

41. On the other hand, there is no evidence of KD expressing suicidal intent or ideation before the night of his death and the statement on the night may have simply been a reference to his chronic health difficulties. In her statement his wife said that she did not believe he would take his own life and he never talked about suicide or displayed suicidal tendencies. There is also evidence that KD was apparently optimistic about the future, and was planning a holiday with his wife and two teenage sons.

42. It has been said that a finding of suicide casts a long shadow. On the evidence I am not able to reach a comfortable level of satisfaction that KD intentionally took his own life. I am not able to determine his intent one way or the other.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was KD, born 1 June 1967;

(b) KD died on or about 16 May 2014, Victoria, from aspiration of gastric content secondary to combined drug toxicity;

(c) his death was the consequence of the deliberate ingestion of drugs, however I am not able to determine his intent at the time; and

(d) the death occurred in the circumstances described above.

Comments

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

1. KD died as a consequence of his ingestion of a number of drugs including benzodiazepines and quetiapine.

2. Royal Australian College of General Practitioners' ('**RACGP**') guidelines in relation to benzodiazepine prescribing state:[4]

   Long-term use, beyond four weeks, should be uncommon, made with caution and based on thoughtful consideration of the likely risks and benefits of benzodiazepines.

   If alternatives to benzodiazepine treatment fail, have limited benefit or are inappropriate (either psychologically or pharmacologically), supervised benzodiazepine treatment may remain an acceptable long-term therapeutic option.

3. Although there appears to be controversy as to whether quetiapine can properly be regarded as a drug of dependence[5], its misuse and abuse among drug dependent people is well

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[4] RACGP guidelines, *Prescribing drugs of dependence in general practice 2015 Part B: Benzodiazepines at 1.6.3, page 17.*

[5] Hanley MJ and Kenna HA, "Quetiapine: treatment for substance abuse and drug of dependence", American Journal of Health-System Pharmacy, 65(7), 2008, pp.611-618; Heilbronn C, Lloyd B, McElwee P, Eade A and Lubman D, "Trends in quetiapine use and non-fatal quetiapine-related ambulance attendances", Drug and Alcohol Review, 32, 2013, pp.405-411; Malekshahi T, Tioleco N, Ahmed N, Campbell AN and Haller D, "Misuse of atypical antipsychotics

documented in addiction medicine literature and is regularly encountered by Victorian Coroners. There is thus a strong rationale to include quetiapine as a target drug in Victoria's real-time prescription monitoring system so that treating doctors are aware when a patient is taking the drug and can ensure its use is clinically appropriate. Additionally, monitoring quetiapine may assist in raising doctors' awareness of the potential for quetiapine misuse; Dr H was clearly unaware of this potential, as he indicated that he had never experienced patients misusing or seeking excessive quantities of quetiapine, to the contrary his only experience was of patients seeking to reduce their intake. .

4. General practitioners Dr B and Dr H explained that their prescribing of benzodiazepines and quetiapine was merely continuing a drug treatment plan first established by psychiatrist Dr Croke. Dr H proffered: *'[a]s is common in psychiatry, once a patient has become stable on a treatment regime they may be discharged from the psychiatrist's care and continue to be managed by their general practitioner on the treatment plan prepared by the psychiatrist.'* Possibly duped by KD, Dr B wrongly believed KD remained under the care of a psychiatrist who he assumed to be Dr Croke. Despite KD's history of drug dependency, Dr B reported that he had '*no reason*' not to believe him. Dr H knew that KD was not seeing Dr Croke but further explained that '*As David was a medical colleague, and one who appeared to be functioning well, [I] respected David's decision to temporarily self-increase his dose of quetiapine*'.

5. It is understandable, perhaps inevitable, that medical practitioners treating a colleague will be influenced by that fact. This case illustrates the need for general practitioners to be vigilant when treating a person with a history of drug dependency, even if they are a colleague. Further, the circumstances of this case raise the question of how often there should be communication between general practitioners who are the primary prescribers and specialists in relation to the ongoing treatment of patients, particularly medication regimes.

Recommendations

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

in conjunction with alcohol and other drugs of abuse", Journal of Substance Abuse Treatment, 45, 2015, pp.8-12; Klein-Schwatz W, Schwartz E and Anderson B, "Evaluation of Quetiapine Abuse and Misuse Reported to Poison Centers", Journal of Addiction Medicine, 8(3), 2014, pp.195-198.

1. The Royal Australian College of General Practitioners consider the need for further education of its members in relation to the potential for misuse of quetiapine given the circumstances of this death.

2. The Royal Australian College of General Practitioners consider the circumstances of this death in the context of its existing guidelines on coordinating care between general practitioners and specialists, and determine whether more practical guidance is required for general practitioners in areas such as:

    (a) How long a general practitioner should rely on specialist prescribing advice before seeking updated advice.

    (b) How often a general practitioner should be in contact with a specialist if the general practitioner is relying on that specialist's advice to inform ongoing care.

Publication

Given that I have made recommendations I direct that this Finding be published on the Court Website pursuant to section 73(1A) of the *Coroners Act 2008*. As the purpose of the recommendations and publication is to improve public safety and in order to avoid any perception of casting blame, I direct that the published Finding be redacted so as to remove information identifying the deceased, the deceased's family and the deceased's treating health professionals.

Distribution

I direct that a copy of the unredacted Finding be distributed to potentially interested parties as below, including Medical Direct Clinical, the producers of the prescription software used by Clinic X at the time KD received his prescriptions.

The Department of Health and Human Services Real-Time Prescription Monitoring Taskforce is included in the distribution list in case this Finding is of assistance in decisions relating to the implementation of the Victorian real-time prescription monitoring system, particularly consideration of what non Schedule 8 drugs should be included in the list of drugs monitored.

I convey my sincere condolences to KD's family.

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

A, Senior Next of Kin

Melanie Robson, Avant Law

Dr B, Clinic X

Department of Health and Human Services Real-Time Prescription Monitoring Taskforce;

Royal Australian College of General Practitioners

Australian Health Practitioner Regulation Agency

Medical Director Clinical, Lvl 5, 72 Christie St, St Leonards NSW 2065

Senior Constable John David Phillips, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 22 February 2017