IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013/2058

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 MARK BRIAN WILSON

without holding an inquest:
find that the identity of the deceased was MARK BRIAN WILSON
born on 9 September 1962
and the death occurred between 11 and 12 May 2013
at Unit 2, 349 Bluff Road, Hampton 3188
from:

1 (a) MIXED DRUG TOXICITY (PROPOFOL, CODEINE, DIAZEPAM)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Mark Brian Wilson was 50 years of age at the time of his death. He lived at Unit 2, 349 Bluff Road, Hampton 3188 and had worked as a Registered Nurse at The Avenue Private Hospital for six years. Mr Wilson had no known history of drug use or evidence of any prior incidents at work.

2. Mr Wilson enjoyed a close relationship with his mother and sister. On 11 May 2013, at approximately 9.00pm, Mr Wilson left work early having complained of being short of breath and feeling unwell.

3. On 12 May 2013 at approximately 3.10pm, Mrs Beverley Wilson (Mr Wilson's mother), Ms Tracey Whithead (Mr Wilson's sister), Ms Jodie Swingler (the Associate Nurse Unit Manager at The Avenue Private Hospital) all attended Mr Wilson's home address. They were concerned about him because he had not attended work and had not called his mother

that day which was considered unusual, especially as it was Mother's Day. They could not gain entry to the house using a key and alerted Victoria Police. At approximately 5.00pm, Victoria Police attended and gained entry using a locksmith. Constable Steven Charlton located Mr Wilson in the first bedroom. Mr Wilson was cold to touch and it was apparent that he was deceased.

INVESTIGATIONS

4. Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr Wilson, and reviewed the post mortem CT scan and the Form 83 Victorian Police Report of Death. The autopsy did not reveal any evidence of significant trauma to the body of a type that might be expected to have contributed directly or indirectly to Mr Wilson's death. Anatomical findings included a tourniquet around the left lower leg and needle puncture mark with underlying haemorrhage at the medial aspect of the left ankle. Other anatomical findings included macronodular cirrhosis of the liver, cystic lung disease with extensive adhesions in the setting of previous bilateral talc pleurodesis and slight myxoid thickening of mitral and tricuspid (cardiac) valve leadlets.

5. Toxicological analysis of blood retrieved post mortem showed the presence of propofol, at a blood concentration of 0.9mg/L. Dr Baker comments in her report that propofol is a short acting intravenous anaesthetic agent that should not be administered in the absence of appropriate cardiovascular and respiratory monitoring and fatalities due to propofol have been reported at blood concentrations of 0.2mg/L. Dr Baker states that adverse reactions include hypotension and convulsions.

6. Toxicological analysis of Mr Wilson's blood also revealed other drugs with what Dr Baker described as having central nervous system depressant effects including codeine,[1] diazepam and its metabolite nordiazepam.[2] Paracetamol and the antidepressant medication sertraline were also detected, however Dr Baker considered they were unlikely to have contributed to death.

---

[1] Codeine is a narcotic analgesic related closely to morphine but having one-tenth of the activity of morphine. Codeine is present in numerous proprietary medicines as tablets containing up to 30mg of codeine phosphate and syrups often in combination with other analgesics such as aspirin and paracetamol. Blood concentrations of codeine halve every two to three hours thereafter.

[2] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

7. Dr Baker stated that cystic disease of the lung and adhesions *may* have contributed to death however noted that the use of propofol in a non-hospital setting can cause death in the absence of any other contributing factor. Dr Baker ascribed the cause of Mr Wilson's death to mixed drug toxicity (propofol, codeine and diazepam).

8. The circumstances of Mr Wilson's death have been the subject of investigation by Victoria Police on my behalf. The police investigation did not identify any evidence of third party involvement. They located a tornaquay tightly secured above Mr Wilson's left calf. On the floor directly behind Mr Wilson was a used syringe and on the desk an open bottle of propofol 200mg/20ml as well as other drug paraphernalia. No expression of intent in the form of a "suicide note" was located.

9. Police obtained statements from Mr Wilson's mother, Beverley Wilson; his sister, Tracey Whitehead; Associate Nurse Unit Manager, Jodie Swingler; Nurse Unit Manager, Lynda Harvison; the out of hours pharamacy co-ordinator, Anne Wilson; Mr Wilson's treating General Practitioner, Dr Menrit Abrahams; and his previous treating General Practitioner, Dr Carl Jansz.

10. Dr Jansz consulted with Mr Wilson from November 2002 until July 2008, and treated him for anxiety and depression. Mr Wilson had been taking antidepressant medication since 2002.

11. Dr Abrahams treated Mr Wilson for a number of conditions that included bilateral pleurodesis and cystic lung disease. Mr Wilson also had a history of spontaneous pneumothorax requiring bilateral pleurodeses, and was managed by a Respiratory Physician based at the Alfred Hospital. Mr Wilson had recently also been diagnosed with Hepatitis C. Dr Abrahams last consulted with Mr Wilson on 11 April 2013. Mr Wilson had not expressed any suicidal ideation to Dr Abrahams.

12. Jodie Swingler states that Mr Wilson was at work on 11 May 2013 and at approximately 9.00pm she sent Mr Wilson home early as he had been complaining of feeling unwell. Mr Wilson sent her a text message at 9.20pm on the same evening to inform her that he had arrived home safely. It was Mr Wilson's failure to attend work on 12 May 2013 that alerted Ms Swingler to call Mrs Wilson. Ms Swingler states that she had noticed that Mr Wilson had been a little down shortly before he died.

13. Beverley Wilson also reports that she had a close relationship with her son and they would usually speak to each other on the telephone three to four times a day. She states that her son's chronic lung disease, which is a result of a hereditary condition, caused him to say on one occasion that he would not want to live if he required supplementary oxygen therapy. She describes this as a passing comment. Mr Wilson had never expressed suicidal ideation to his mother.

14. With regard to Mr Wilson's access to the drug propofol, Lynda Harvison states that the drug is kept on the resuscitation trolley in the ward and is checked weekly by two nurses to ensure all drugs are present and in date. Sarah Barlow, a Registered Nurse who worked with Mr Wilson, confirms in her statement that on 21 April 2013, she and Mr Wilson conducted one of these checks and found that two of the vials of propofol were out of date. Mr Wilson offered to collect all of the expired drugs and went to another ward to collect other in date drugs. It was not uncommon to do this on a Sunday as the pharmacy was closed. Ms Harvison also states that she believes that it is highly possible that Mr Wilson took additional propofol from the theatre room at this time.

15. Anne Wilson states that on 21 April 2013 she received from Mr Wilson two vials of propofol which he informed her were out of date. Mr Wilson did not ask her for any replacements.

16. Additional information was sought from The Avenue Hospital including clarification of who monitored the theatre CCTV, how long recordings were kept, who has the security code to enter the theatre, and whether ward staff would have the theatre security code.

17. Lynda Harvison confirmed in a letter dated 12 May 2014 that the CCTV footage was kept for a one month period. The theatre room CCTV was monitored only when there was work being carried out by the maintenance department. Ms Harvison also confirmed it was very rare for ward staff to have the code and only theatre staff and the hospital coordinator have the code. Any ward staff should be accompanied by a theatre staff member when accessing the theatre room.

18. Although it is unclear from the investigation exactly where and when Mr Wilson obtained the propofol from, since Mr Wilson's death, The Avenue Hospital has now installed CCTV cameras in the theatre drug room to monitor access to the area. The security code is changed

three times per month and staff from other departments may only enter if accompanied by a theatre staff member.

COMMENTS

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

In a similar case involving the use of propofol by a hospital staff member, Coroner Spanos commented in the case of AB (court reference COR 2012 004565) about deaths associated with health care professionals accessing and misusing general anaesthesia and associated drugs. In a Coroners Prevention Unit (CPU)[3] review of coronial cases, it was noted that 15 of the 15 identified Victorian deaths between the period of 2000-2013 using general anaesthetics and neuromuscular blocking agents as a means of death were all of people who worked in the medical profession and had access to the drugs by virtue of their employment.

Coroner Spanos commented that she understood that it could be onerous to lock away high volume medication especially in relation to drugs that need to be used in an emergency department/trauma centre. However, this is not the case involving drugs that are used in an operating theatre as there is usually ample planning and set up time. Therefore, there is less rationale for leaving the drugs in easily accessible areas.

Coroner Spanos further commented that the number of people that had died, regardless of intent, who were using general anaesthetics and neuromuscular blocking agents was not substantial unless it was viewed as a specific occupational hazard, through ease of access. Her Honour observed that the hospital involved in this case had made changes in relation to ease of access by hospital staff to such drugs.

Coroner Spanos recommended that the Victorian Department of Health (the Department)[4] consult with Victorian hospitals regarding Victorian overdose deaths from the misuse of neuromuscular blocking agents and/or general anaesthetic agents, and seek their advice on whether any further measures can be implemented to reduce the misuse of these agents.

---

[3]The Coroners Prevention Unit (CPU) is a specialist service comprising a team of investigators and health clinicians. The CPU assists coroners fulfil their prevention role and contribute to a reduction in preventable deaths.

[4] Now known as the Department of Health and Human Services.

In their response dated 11 July 2014, the Department responded that the responsibility for managing and mitigating risk sits with the health services, who do this through their clinical risk management committees and associated governance structures. The Department stated that they had communicated with both the Australian and New Zealand College of Anaesthetists' Welfare of Anaesthetists Special Interest Group (SIG) and the Victorian Therapeutic Advisory Group (VicTAG) in relation to the case of AB and that the Department would continue to promote personal and psychological wellbeing of Anaesthetists and heighten awareness of health issues in Anaesthetists. VicTAG would use the support guidelines and recommendations around management of drugs in the operating suite in Victorian hospitals and would raise these points at their next meeting.

RECOMMENDATIONS

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

In light of the response received by Coronor Spanos in the investigation into the death of AB, I recommend that the Department of Health and Human Services consult with Victorian hospitals, the Australian and New Zealand College of Anaesthetists' Welfare of Anaesthetists Special Interest Group and the Victorian Therapeutic Advisory Group and obtain an update in relation to hospital practices now in place to manage and mitigate the risks associated with the misuse of neuromuscular blocking agents and/or general anaesthetic agents by medical and allied health staff. They should report whether there have been any changes in the support guidelines and recommendations following the aforementioned meeting.

FINDINGS

I accept the changes made by The Avenue Hospital in response to Mr Wilson's death are restorative in nature, and aimed at preventing like deaths in the future. I make no adverse finding against The Avenue Hospital.

I accept and adopt the medical cause of death as identified by Dr Baker and find that Mr Mark Wilson died as a result of mixed drug toxicity (propofol, codeine and diazepam) in circumstances where, due to his professional background, I am satisfied that he would have knowledge of the use of the drug and its likely outcome.

Although the investigation did not identify any specific precipitating factors, I am nonetheless satisfied the Mr Wilson has died in circumstances where he intended to take is own life.

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

Mrs Beverley Wilson

Ms Tracey Whitehead

Detective Sergeant Gerry Richardson

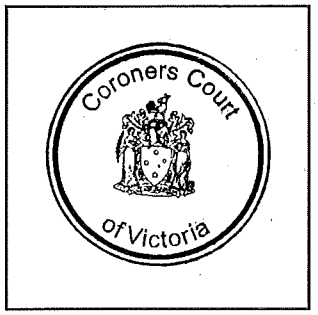
The Avenue Hospital

Dr Pradeep Philip's secretary at the Victorian Department of Health and Human Services

The Australian and New Zealand College of Anaesthetists' Welfare of Anaesthetists Special Interest Group

The Victorian Therapeutic Advisory Group

Signature:



AUDREY JAMIESON
Coroner
Date: **22 April 2015**