IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 004313

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Ms RF
Date of birth:	13 September 1963
Date of death:	Between 17 and 25 September 2013
Cause of death:	Potentially fatal multiple drug toxicity (oxycodone, mirtazapine, citalopram, clonazepam, pregabalin) in a woman with epilepsy
Place of death:	Frankston

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of Ms RF without holding an inquest:

find that the identity of the deceased was Ms RF

born on 13 September 1963

and that the death occurred between 17 and 25 September 2013

at an address in Frankston, Victoria 3199

from:

I (a) POTENTIALLY FATAL MULTIPLE DRUG TOXICITY (OXYCODONE, MIRTAZAPINE, CITALOPRAM, CLONAZEPAM, PREGABALIN) IN A WOMAN WITH EPILEPSY

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

1. Ms RF was a 50-year old single woman who lived alone in Frankston. She was the youngest of seven siblings born to self-employed parents. According to a sister, Ms RF was subjected to childhood sexual abuse by one of their brothers and, in addition, as an adult was estranged from various siblings at different times. She remained close to her parents, however, providing assistance to her father in the terminal stages of cancer and supporting her mother following her diagnosis with dementia.

2. In the mid-1980s, Ms RF sustained a wrist injury at work. She underwent multiple surgeries but did not regain full function in her wrist and experienced ongoing pain. She eventually received compensation for the injury which enabled her to buy a home. However, Ms RF's inability to maintain paid employment long-term produced financial strain, and prompted her to move and downsize in 2001, 2008 and again in 2010, when she moved to Frankston.

3. Ms RF's medical history included epilepsy, thalassaemia minor, depression and chronic severe pain secondary to a workplace wrist injury and, after 2010, pain and reduced function in both arms associated with cervical spine foraminal stenosis. Her general practitioner, Dr Daniel Bergman of the Durrant Street Medical Clinic and later of the Southland Medical Centre, prescribed a number of medications regularly. These medications included anticonvulsants topiramate and carbamazepine through which Ms RF's epilepsy was well-controlled, antidepressants mirtazapine and escitalopram, paracetamol/codeine analgesia for pain, and a benzodiazepine, temazepam, to aid sleep.

4. In addition to prescribing analgesia, Dr Bergman referred Ms RF to publicly-funded orthopaedic and pain management specialists for review. Waiting lists for outpatient assessments of these types were lengthy and often resulted in re-referral to a different specialist clinic.

5. In August 2013, Ms RF was reviewed by neurosurgical specialist Professor Jeffrey Rosenfeld at The Alfred Hospital. He noted some incongruity between her reported symptoms and imaging from the previous year, and foreshadowed in correspondence to Dr Bergman his likely reluctance to recommend surgical intervention in the absence of demonstrated significant nerve compression in imaging to be performed in September 2013. Prof Rosenfeld also noted that Ms RF had requested a prescription for analgesia and that he had declined to provide one.

6. On 9 September 2013, after a magnetic resonance imaging [MRI] scan, Ms RF was informed by Prof Rosenfeld's colleague Dr Moore that her condition was unlikely to improve with surgical intervention and she was referred to the chronic pain clinic.

7. On 12 September 2013, Ms RF attended an appointment with Dr Bergman. It was clear to the GP that she was 'not pleased' with the outcome of the neurosurgical review but appeared to 'hold it together'. Dr Bergman suggested a second opinion from a private specialist but Ms RF declined for financial reasons.

8. On 17 September 2013, Ms RF attended a medical appointment at Beach Street Family Medicine.[1]

9. On 25 September 2013, Ms RF's friend Stanley Livingston called police and asked them to perform a welfare check because he had been unable to reach her. On arrival, police found the back door open and, on entering, found Ms RF lying on the kitchen floor, apparently deceased.

10. Constable Jason Nowakowski of Frankston Police commenced an investigation of the circumstances in which Ms RF died. The scene was photographed and during a search, police found a large number of prescription medications including pregabalin, oxycodone, carbamazepine, clonazepam, escitalopram, mirtazapine and topiramate, but saw no signs that another person was involved in the death. C/ Nowakowski later prepared the brief of evidence on which this finding is largely based.

11. Forensic pathology registrar, Dr Gregory Young of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police, post-mortem computer assisted tomography [PMCT] scans of the whole body, available medical records and performed an autopsy under the supervision of forensic pathologist, Dr Jacqueline Lee. Among Dr Young's anatomical findings were widespread decompositional changes, the absence of any recent significant injury that may have caused or contributed to death,

[1] This was the third of the three consultations between Ms RF and Dr Fenella Karis.

moderate atherosclerosis but no myocardial fibrosis and no epileptogenic focus – no tumour, arteriovenous malformation or gliosis – identified in the brain.[2]

12. Post-mortem toxicology detected oxycodone,[3] mirtazapine,[4] citalopram,[5] metoclopramide, carbamazepine, pregabalin,[6] topiramate and the metabolite of clonazepam[7] in blood and codeine, morphine, oxazepam, temazepam, diazepam and its metabolite, and paracetamol in urine. Dr Young observed that while interpretation of post-mortem drug levels can be problematic, the combination of drugs detected in Ms RF's samples were likely to cause significant central nervous system depression which can lead to potentially fatal respiratory depression.

13. Dr Young commented that on the basis of his findings at autopsy he was unable to eliminate the possibility that epilepsy had contributed to Ms RF's death in light of her medical history. Similarly, the presence of a potentially fatal combination of drugs prevented a positive determination that Ms RF's death fell into the category of sudden unexpected death in epilepsy [SUDEP].[8]

14. Accordingly, Dr Young advised that it was reasonable to attribute the cause of Ms RF's death to *potentially fatal multiple drug toxicity (oxycodone, mirtazapine, citalopram, clonazepam, pregabalin) in a woman with epilepsy.*

15. At my request, Medicare and Pharmaceutical Benefit Scheme [PBS] records were obtained for the period 1 September 2009 to 25 September 2013. Medicare records demonstrated that Ms RF's consultations with general practitioners occurred with increasing frequency: there were five attendances in 2010, 43 in 2011, 159 in 2012 and 173 between 1 January and 25 September 2013.

16. The Medicare and PBS records suggested that Ms RF engaged in 'prescription shopping' for narcotic analgesics, specifically codeine/paracetamol.[9] In 2013, she consulted six general

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[2] Dr Young noted that the neuropathological examination was compromised by changes of decomposition such that subtle changes in the brain may not have been evident.
[3] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine and used clinically to treat moderate to severe pain.
[4] Mirtazepine is an antidepressant.
[5] Citalopram is an antidepressant.
[6] Pregabalin is a drug used as an analgesic, anticonvulsant and anxiolytic agent.
[7] Clonazepam is a sedative/hypnotic of the benzodiazepine class.
[8] SUDEP stands for sudden unexplained death in epilepsy. Deaths attributed to SUDEP require, amongst other things, a negative autopsy and ancillary investigations.
[9] While Ms RF's anticonvulsant and antidepressant medications were prescribed almost exclusively by Dr Bergman and appear to have been used in accordance with his dosing instructions, the frequency with which temazepam scripts were provided, and by implication used, increased exponentially during 2013: by August-September 2013 Ms RF was prescribed and supplied about twice as many tablets as would be required for the period if used as directed. See Ms RF's PBS records: compare January-February 2013 when 75 tablets were prescribed and dispensed, commensurate with the amount required if using the maximum prescribed dose for the period (two tablets every day for two months) with

medical practices, received prescriptions from 21 GPs and attended six different pharmacies regularly to have these prescriptions filled. With few exceptions, codeine/paracetamol was prescribed 20 tablets at a time with dosing instructions indicating that the supply should not be depleted before the expiration of a week.[10] However, between 1 January and 12 September 2013, Ms RF's medical attendances where codeine/paracetamol was prescribed averaged 11 per month, such that she was able to access – on average – about three times the maximum dosage recommended by the prescriber every month for nine months, in addition to her other medications.[11]

17. Additionally, in August and September 2013, Ms RF presented to Dr Fenella Karis for management of chronic pain in her wrist and neck and was prescribed oxycodone slow release on a gradually increasing dose over four weeks, oxycodone for 'break through pain' and pregabalin.[12]

18. Overall, during September 2013, Ms RF was prescribed and supplied 180 codeine/paracetamol tablets, 112 pregabalin, 96 oxycodone, 50 temazepam, 28 escitalopram, 30 mirtazapine and 120 topiramate tablets.[13]

19. In light of the apparent ease with which Ms RF was able to access large quantities of prescription medications, I asked her primary prescribers to provide statements about their clinical management. It was evident from the materials provided that each clinician had a sound clinical basis for providing the codeine/paracetamol prescriptions s/he did, given Ms RF's reported history of wrist injury and shoulder and neck and pain and their examination findings.[14] It was also clear that the GPs had been mindful of the frequency with which scripts were provided in light of their dosing instructions.[15] None of the GPs were aware that

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August-September 2013 when 150 tablets had been prescribed and dispensed by 12 September 2013. Dr Bergman, the only temazepam prescribed, recommended that Ms RF taken a 'maximum of two' tablets per night.

[10] See Ms RF's PBS records: only clinicians at Medical One prescribed Ms RF codeine/paracetamol in quantities greater than 20 tablets per prescription: they provided scripts for 60 tablets at a time.

[11] Attendances by month between January and September 2013 are 8, 5, 15, 16, 16, 6, 11, 18 and 6.

[12] See Ms RF's PBS records for August-September 2013 and Dr Karis' correspondence dated 8 February 2015. I note that Dr Karis agreed to taken on management of Ms RF's chronic pain provided she only consult her for prescriptions of narcotic analgesia.

[13] See generally Ms RF's PBS records for September 2013.

[14] See generally the correspondence and/or medical records provided by Dr Fenella Karis (who saw Ms RF at Beach Street Family Medicine) dated 8 February 2015, Dr Tony Marshal of the Playne Street Medical Centre dated 16 January 2015, Dr Tiesheng Wang of Medical One Frankston dated 3 February 2015 and Dr Daniel Bergman of Durrant Street Medical Clinic and Southland Medical Centre dated 9 September 2014 and 29 April 2015. I note that none of the clinicians consulted by Ms RF at Young Street Medical and Dental Centre responded to requests for statements. I note in particular that Dr Marshal and Dr Bergman both referred Ms RF to orthopaedic, neurological, physiotherapy, radiology and pain management specialists for assessment and/or treatment.

[15] Ibid.

Ms RF was accessing similar prescriptions elsewhere and nothing about her presentation caused them to be suspicious that she was a 'prescription shopper'.[16]

20. I find that Ms RF, late of an address in Frankston, died there between 17 and 25 September 2013 and that the cause of her death was potentially fatal multiple drug toxicity involving oxycodone, mirtazapine, citalopram, clonazepam, and pregabalin in a woman with epilepsy. The circumstances of Ms RF's death are consistent with inadvertent overdose.

21. The available evidence does not support an adverse finding or comment about any one of Ms RF's prescribing clinicians given the information available to them at the time they provided their prescriptions.

COMMENTS

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

1. It is axiomatic that 'prescription shoppers' like Ms RF exploit gaps in their prescribers' (and dispensers') knowledge to access inappropriate quantities of prescription medication. The prescription shopper's pursuit of his/her objective is unlikely to be thwarted efficiently or effectively by individual clinicians in possession of only some of the available clinically relevant information. Indeed, numerous coronial investigations attest to the fact that curtailing 'prescription shopping' requires a comprehensive, systematic and real-time solution to the information deficit that impedes coordination of medical care.

2. For more than a decade Victorian Coroners have recommended the development and implementation of a real-time prescription monitoring system to prevent ongoing harm and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.[17] Ms RF's death again highlights the benefits such a scheme could have in saving lives. I am aware of the work already undertaken by the Commonwealth and States towards the realisation of a real-time prescription monitoring system, the complexity of the task and that its implementation will result in significant changes

[16] Ibid. However, Dr Karis noted 'Pt had been flagged as concern for chronic pain medications addiction' on the basis of other practitioners in the same practice having previously been cautious about prescribing analgesia for her wrist injury. Dr Karis, however, on the basis of documents Ms RF brought with her to the consultation relating to her attendances on Prof Rosenberg, reached a different conclusion, namely, that there was a legitimate medical reason so as to make it 'valid to use narcotics'.

[17] See for example State Coroner Judge Gray's Finding into the death of Anne Brain (COR 2011 4794), and Coroner Olle's Findings into the deaths of James Dougan (COR 2010 4459) and Jamie Apap (COR 2010 3678), the Finding of Coroner Jamieson into the death of Kirk Adern (COR 2012 3354), and my own Findings into the deaths of Dean Wright (COR 2011 0727) and Benjamin Appelman (COR 2010 4762).

to clinical practice in Australia. Nonetheless, preventable deaths, like Ms RF's continue to occur.

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

Ms RF's sister

Dr Daniel Bergman, c/- Southland Medical Centre

Dr Tony Marshal, c/- Playne Street Medical Centre

Dr Tiesheng Wang, c/- Medical One Frankston

Dr Fenella Karis, c/- Southland Medical Centre

Practice Manager, Durrant Medical Clinic

Practice Manager, Young Street Medical and Dental Centre

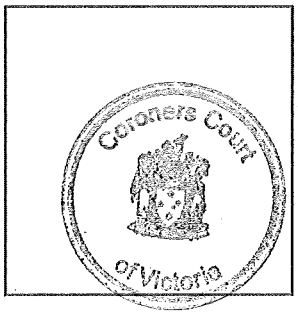
Practice Manager, Beach Street Family Medicine

Victorian Department of Health and Human Services Drugs & Poisons Regulation

Commonwealth Department of Health

Constable Jason Nowakowski, Frankston Police

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 20 June 2017