IN THE CORONERS COURT
OF VICTORIA
AT LATROBE VALLEY

Court Reference: COR 2012 / 0367

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: PAUL KANIS

Delivered On:	17th December 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Vic 3006
Hearing Dates:	10th to 11th July 2014
Findings of:	JACINTA HEFFEY, CORONER
Representation:	Acting Sergeant Grieg McFarlane – Police Coronial Support Unit Mr Paul Halley of Counsel - Representing Dr Bernard Rooney

I, JACINTA HEFFEY, Coroner having investigated the death of PAUL KANIS

AND having held an inquest in relation to this death on 10th to the 11th July 2014

At LA TROBE VALLEY CORONERS COURT

find that the identity of the deceased was PAUL KANIS

born on 7th August 1973

and the death occurred on 30th January 2012

at Victory Park, Traralgon 3844

from:

1 (a) ORGANIZING PNEUMONIA WITH LOCULATED PLEURAL EFFUSION IN THE SETTING OF DRUG USE INCLUDING METHADONE AND BENZODIAZEPINES IN A MAN WITH SIGNIFICANT CO-MORBIDITIES INCLUDING ASTHMA

in the following circumstances:

1. Paul Kanis was a 38 year old man with a long history of mental illness. He lived alone in a rented unit in Traralgon with his dog, Max. He was very close to his family. According to his mother, Paul's mental problems dated back to his father's murder in 1988, just before his 15th birthday. The family lived in Western Australia until 2001. After Paul's 8 year relationship with his girlfriend (during which, according to his mother, Suzie Kagie, he had been introduced to hard drugs[1]) had ended, at the age of 27 he moved back to Victoria where his family now lived. From all accounts he was a kind person who, at times, was taken advantage of. His two treating doctors in Traralgon (who will be referred to later in this Finding), were clearly fond of him and were distressed by his death.

2. At about the time he returned to Victoria, he was diagnosed with insulin-dependent diabetes. He also suffered from asthma. He had been diagnosed with Hepatitis C, suffered periodically from bronchitis and chest infections. He was a regular smoker of cigarettes. His constant and on-going problems, however, were his drug dependency and his mental health problems. He often presented as very anxious and agitated. He had been diagnosed as suffering from schizoaffective disorder and had had at least one psychotic episode.

3. In relation to his drug dependency, Dr Bernard Rooney, a GP in Traralgon for 37 years, who is an authorised opioid replacement therapy (ORT) doctor, was treating him. He told the court that he is one of only three doctors so qualified in the Latrobe Valley region. He runs a

[1] Paul's sister Anica, in her statement, ascribed Paul's opioid addiction to having been on morphine for a long time for pain following a broken wrist a few years earlier.

weekly clinic in Traralgon for people with substance abuse problems. He had been managing Paul's drug dependency since 2008.

4. GP Dr Daryl Ham, who attends the Hillcrest Medical Centre every Wednesday, looked after Paul's mental health problems. He had been treating Paul since 2002.

5. Neither of these doctors had ever met or spoken to each other. There had been no communication between their practices. They only knew any details of their respective roles in Paul's treatment to the extent that Paul had informed them.

6. Dr Rooney had commenced Paul on Suboxone therapy soon after he started treating him in 2008. The dosage stabilised at 8 mg daily after a number of reviews. On the 11th January 2012, however, Paul told Dr Rooney that he wished to transfer to the Methadone programme as he said the Suboxone was causing vomiting and headaches. Dr Rooney agreed to this, commencing him on 50 mg daily, which could be increased to 80 mg "*if required*". He gave him a prescription that was valid for 60 doses.

7. That same day, Paul attended Dr Ham[2]. There is no note in Dr Ham's records of Paul complaining of nausea or headaches. Rather, what is recorded is that he told Dr Ham he had mislaid his Rivotril tablets (clonazapam) and had not had any for a few weeks. Given the withdrawal difficulties this would have caused, Dr Ham was disinclined to believe that this was the true time-frame. He refused to prescribe more having previously indicated that there must be at least 30 days between prescriptions, the last having been given on the 28th December. Instead, he advised Paul to make do in the meantime with valium.[3]

8. Dr Ham told the court that at no time did Paul mention that he was proposing to change from Suboxone to Methadone. Nor did he mention that he was about to see, or had already seen, Dr Rooney for this purpose that day.

9. Dr Rooney saw Paul again on the 25th January 2012. He reported some withdrawal symptoms as a result of which Dr Rooney increased the dosage to 85 mg per day and advised the dispensing pharmacy, Priceline in Traralgon, of this. Although he made no note of it, he recalled that Paul had a cough and told him that he was going to see Dr Ham immediately afterwards about it. Dr Ham has no record of seeing Paul on that day.

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[2] Neither doctor made any note of the time of the appointment that day. Hence, it is not possible to establish which doctor Paul had seen first.

[3] Toxicological analysis post mortem revealed the presence of clonazepam in his blood. The elimination half-life is typically 30-40 hours.

10. On Saturday, the 28th January 2012, Paul telephoned his sister Anica in a distressed state saying he was having difficulty breathing. He had gotten a ventolin inhaler from the pharmacy which apparently had little effect. He was very scared. She convinced him to call an ambulance.

11. A Mobile Intensive Care Ambulance attended his address at 4.20 PM that afternoon after he called the service complaining of shortness of breath. According to statements provided by both paramedics, they found Paul extremely agitated, pacing and talking quickly. Vital observations were normal apart from a marginally elevated respiration rate (which would not be unusual in an agitated patient). The paramedics' examination included a Respiratory Status Assessment which is "*a targeted nine-point assessment endorsed by Ambulance Victoria and used to categorise a patient's degree of respiratory distress*". Specifically, there was no wheeze or any other unusual sounds. Notwithstanding that in the view of the paramedics, Paul did not require hospital assessment, they offered to take him to Latrobe Regional Hospital. This he declined, as by now he had been re-assured that he was not having an asthma attack. However, because of his concern about his now empty inhaler, they offered him transport to the pharmacy to collect a replacement inhaler, which offer he accepted. I am satisfied that there is nothing to criticise in the conduct of the ambulance officers. A post-incident review by Ambulance Victoria came to the same conclusion. I do not consider that the paramedics should be criticised for failing to notice some take-away dose bottles of methadone in his unit. He had volunteered to them that he suffered from asthma, diabetes type 1 and Bi-polar Disorder. He did not tell them about any medication he was on or that he was on the methadone programme. Similarly, he had not told Dr Ham about this. His mother believed he was seeing Dr Rooney for treatment of his diabetes.[4]

12. On Sunday 29th January, he spoke to his sister by phone for nearly 20 minutes. In her statement, she said that he sounded calmer but "*his breathing didn't sound right*". He was planning to see Dr Ham the following Wednesday. Dr Ham looked after his mental health problems and only worked there on Wednesdays. It is clear from the Hillcrest Clinic records, however, that he had seen other doctors about non-mental health issues on other days of the week. One can assume, therefore, that he did not regard his breathing problems on the Sunday as requiring urgent review.

[4] Statement of Suzie Kagie. Inquest Brief P. 20.

13. On Monday, 30th January 2012 at about 5.30 AM, Robert Kyrgsman was walking his dogs in Victory Park when he saw the body of a male lying on the ground. A dog, which had apparently been with the male, approached him and he went towards the body. It was clear that the male was deceased and beyond any assistance, Mr Krygsman could provide. The male was later identified as Paul Kanis.

14. Dr Jacqueline Lee conducted an autopsy at the Victorian Institute of Forensic Medicine. She determined the cause of death as stated above. However, I have added the feature of asthma, as suggested by Mr Halley, Counsel for Dr Rooney.

15. A review of the medications being prescribed to Paul Kanis at the time of his death by Dr Ham reveals a significant array of central nervous system suppressants. In particular, Paul was taking various types of benzodiazepines, amongst which was the regular administration of clonazepam (often dispensed as Rivotril). This drug was prescribed "*off-label*" by Dr Ham. It can only be prescribed for epilepsy (with PBS Authority approval) and there was no evidence that Paul suffered from this. In relation to off-label prescribing, the onus is on the prescriber to defend and justify the use of the medication for some reason other than an approved indication. Entries in Dr Ham's records suggest that it was prescribed for an "*anxiety disorder*".

16. Dr Cameron Loy, an expert in the field of ORT, told the court that the evidence for clonazepam assisting in this condition is very tenuous. He quoted the UK National Institute for Health and Care Excellence, which recommends against the use of benzodiazepines generally for the treatment both of generalised and social anxiety disorders. If used at all, it should be used only as a short time measure during a crisis. For treatment of social anxiety disorders, if used at all, is it used in lower doses and mostly in combination with SSRIs.[5]

17. Dr Loy was critical of the prescribing performed by Dr Ham. He said that the apparent "*anxiety*" that Paul was suffering was possibly withdrawal symptoms rather than the anxiety for which it was originally prescribed. Dr Ham defended his prescribing practice telling the court that in the ten years he had been treating Paul, the time was never right to start weaning him off benzodiazepines.[6] In his defence, Dr Ham expressed frustration at the difficulties he regularly encountered in that often these medications are already being used by his patients

[5] Selective Serotonin Reuptake Inhibitors (a type of anti-depressant).

[6] The deceased was also prescribed Quietiapine (Seroquel) – According to Dr Loy, there is growing concern in the community about the use of this drug due to its centrally sedating effect and addictive potential. He had been prescribed Oxazepam until 2008. He was prescribed Diazepam (Valium).

when they come to him and he finds that the doses are increased when they are admitted to psychiatric wards, making it more difficult for him to reduce the dependency later. He said that he felt very isolated, being he said "*the only doctor in the Latrobe Valley with an interest in mental health.*" He listed various doctors who had now left the region. He told the court that "*I wish I could share the load around a bit but ...no other GPs are willing to take on mental health issues*". He said that there were only now two psychiatrists in private practice and they only practiced on weekends.

18. Dr Ham said that it would have been very hard to get Paul off benzodiazepine dependency as he had had many psycho-social stresses, lived alone and was highly anxious. Getting his diabetes under control, his alcohol abuse and until recently, his housing issues, had meant that the time was never right to begin the difficult task of weaning him off dependency on benzodiazepines. He was worried that, if the attempt was made, it may mean that Paul would drink more heavily and go back to illicit drug use on a bigger scale.[7] He agreed with Dr Loy that ideally, benzodiazepines should be used for a minimum period of time but "*not all patients can be managed short term with benzodiazepines because they can go back onto other substances to relieve their anxiety and agitation and these*" (he instanced alcohol and cannabis) *are much more harmful in his view.* He expressed no view on whether withdrawal symptoms can be misinterpreted as anxiety.[8]

19. The family of the deceased was angry at the suggestion that Dr Ham had not done all in his power to help Paul. However, the real issue in this case relates to the cause of death, rather than the medical management of Paul to that point. It may be argued that the prescribing methods of Dr Ham were less than ideal, but Paul did not die from them. He died, clearly, from the *combination* of the regime of benzodiazepines that he was on when methadone was introduced in to his prescribing regime. The fact that this combination occurred without the knowledge of either of his treating doctors is the real issue here.

20. As stated in paragraph 5 above, each doctor knew of the involvement of the other. It seems that they depended on Paul, a lay person, to keep them informed of the treatment being provided to him by the other. Dr Ham said that had he known that Paul had switched to methadone, he would have been very concerned. However, he did not say what he would

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[7] Transcript P 125.

[8] Dr Loy's evidence was that the clinical notes suggest that dose changes were made by Dr Ham based on presentation rather than diagnoses.

have done about it. He had already decided that the time was not ripe to try to wean Paul off the benzodiazepines. Similarly, Dr Rooney was not fully informed of the prescriptions being ordered by Dr Ham, other than what Paul told him.

21. Dr Rooney agreed that it would have been prudent of him to have made contact with Dr Ham to advise him of the switch to methadone. His reasoning in going ahead with the switch, notwithstanding his knowledge that Paul was on clonazepam and diazepam, he told the court, was that unless he acceded to Paul's wishes in this respect (and he noted that Paul had presented in a very agitated, negative state) he was concerned that he would start injecting again. This was the same reasoning behind Dr Ham not commencing any detoxification process with Paul in relation to his dependence on benzodiazepines.

22. Of course, the fact remains that Paul himself did not volunteer to Dr Ham that he was proposing to change (or had changed) his ORT medication. However, the system should not rely on patients communicating this sort of information to doctors. Delegating this role to a lay patient is a dangerous course, particularly when the alternative is as simple as picking up a phone. In this case, the onus was on Dr Rooney to do this, given that he was the one making the changes. However, as a general principal, ideally there should have been communication between the two doctors as a matter of course earlier in the piece. I am mindful of how busy each of these doctors was at the time, but given their evidence that they were each fairly isolated in the particular service they were offering in the area, it would have been beneficial to both of them to meet and also for their shared patients. Over the years, the difficulties created by "*dual diagnosis*"[9], including difficulties in being admitted to respective treatment centres, have featured regularly in the deaths investigated by this court. Effective communication between primary health providers in each field can only be for the benefit of the patients with these dual problems.

23. In terms of Dr Ham's prescribing, Dr Loy did not dispute that there would be doctors who would defend long term use of benzodiazepines.[10] He believed, however, that this position was changing and instanced draft prescribing guidelines being currently being worked on by the Royal Australasian College of General Practitioners. Without seeing the final product, it is not possible to comment on this.

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[9] The phrase "dual diagnosis" relates to a diagnosis of both mental ill-health and drug-dependency.

[10] Transcript P 30.

24. In terms of Dr Rooney's failure to alert Dr Ham to the change of ORT and the observation that his notes were very sparse and of no value to anyone else reading them, Dr Rooney told the court that he is now better supported and works as part of a large team supplied by the Community Health Centre. He has two support workers, (one working with opioid dependent patients, the other with patients addicted to cannabis and valium) and also a nurse prescriber. As a team, they discuss the best course for the patient and the nurse follows up anybody who is changing treatment. The practice now is that the support worker gets a signed authority from the patient so that the team can contact any other doctor treating the patient. Dr Rooney said that he would support any recommendation that doctors who are co-prescribing communicate with each other.

25. Dr Loy told the court of the arrangements in Tasmania in which the doctor who manages the ORT is also the only doctor who can prescribe benzodiazepines. Whilst this appeals as a matter of logic, whether this could be implemented in Victoria with its greater population and densities is beyond the scope of this Inquest. However, I note that even if it were impractical in Victoria to implement a requirement that benzodiazepines are only prescribed to ORT clients by the treating ORT physician, there is scope through a properly implemented real-time prescription monitoring system to at least ensure that all clinicians involved in the care of an ORT client know what the other is prescribing.

26. The suggestion of doctors having access to real time prescription monitoring electronically has been made many times in this court. I instance the following as an example:

- Finding with Inquest into the death of Anne Brain, COR 2011 4797, delivered by State Coroner Judge Ian Gray on 30 October 2014.
- Finding without Inquest into the death of Glen David Kingsun, COR 2007 2556, delivered by Coroner Jacinta Heffey on 28 July 2014.
- Finding with Inquest into the death of Georgia Cheal, COR 2006 4603, delivered by Coroner Jacqui Hawkins on 15 May 2014.
- Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014.
- Finding without Inquest into the death of David Trengrove, COR 2008 4042, delivered by Coroner Audrey Jamieson on 18 May 2012

27. In the Finding in respect of the death of Kirk Steven Ardern, above, Coroner Audrey Jamieson appended a report from the Coroners Prevention Unit (CPU) regarding Victorian drug overdose deaths that occurred between 2010 and 2013. The appendix included a list of the most frequent individual contributing drugs in Victorian overdose deaths. I note that the top contributing drug overall was diazepam, which is a Schedule 4 benzodiazepine. Other Schedule 4 drugs among the top contributors included quetiapine, mirtazapine, nitrazepam, amitriptyline, citalopram, temazepam and venlafaxine. Codeine (which can be a Schedule 3 or Schedule 4 pharmaceutical depending on the formulation and amount of codeine per tablet) was also a top contributing drug. The overdose deaths data shows clearly that Schedule 4 drugs are tremendous contributors to overdose deaths in Victoria.

28. I note further that between 2010 and 2013, the number of Victorian overdose deaths involving **clonazepam** steadily climbed from nine to 19. I have been advised by the CPU that in the first half of 2014, alone, there were a further 16 overdose deaths involving clonazepam, with the full-year total projected to be approximately 30. This represents yet another annual increase.

29. Dr Loy identified some problems with reliance on a real time prescribing system if certain drugs were excluded for example by a patient objecting to having his/her prescribing history published in this way. In my view, the information should be captured at the point of **dispensing,** rather than prescribing. This would involve the co-operation of pharmacists but following the Finding in Kingsun (above) I received supportive responses from The Pharmacy Guild of Australia and the Pharmaceutical Society of Australia in terms of readiness to co-operate in facilitating such a scheme.

A. COMMENT REGARDING THE RURAL ISSUE

Greater communication and professional exchange between practitioners in a particular rural area could be beneficial for coordinating patient care, and could also assist in reducing the experience of isolation that can accompany practicing medicine in a rural setting. I have no specific ideas or recommendations on how to treat this, however I distribute this Finding for information to the relevant organisations who represent rural medical practice, in case it can assist them in their work.

B. COMMENT- REGARDING RTPM

The former Victorian Health Minister David Davis announced a commitment to funding the implementation of a real-time prescription monitoring programme if re-elected. The electoral

outcome was a change of government. As far as I am aware, the in-coming Labour government has not announced any official position regarding RTPM implementation. Therefore, I take this opportunity to draw the new Minister for Health's attention to the on-going issue of pharmaceutical drug overdose in Victoria and the vital – and universally acknowledged – need for an RTPM system to reduce the harms and deaths associated with pharmaceutical drugs.

RECOMMENDATION REGARDING RTPM

As a matter of urgency, the Victorian Department of Health must implement a real-time prescription monitoring system that records information on dispensing of all Schedule 8 drugs and all Schedule 4 drugs of dependence in Victoria and makes this information available to all Victorian pharmaceutical drug prescribers and dispensers, so they can use the information to inform their clinical practice and reduce the harms and deaths associated with pharmaceutical drugs.

C. COMMENT- REGARDING ORT CO-ORDINATION

The circumstances of Paul Kanis' death highlight a major known issue with delivery of ORT in Victoria. The issue is that because of demand for ORT doctors' services, they rarely have time to do anything other than treat opioid dependence, and therefore must by necessity direct patients to other doctors for treatment of any other conditions. This can lead to a situation where (as in the case of Paul Kanis) ORT and other doctors do not communicate with each other - or indeed may not even know about one another - and separately prescribe drugs that can interact to produce toxic effects.

I note that the 2013 Victorian Department of Health *Policy for Maintenance Pharmacotherapy for Opioid Dependence* includes a very brief section on the importance of a collaborative approach to treatment, which reads (page 13):

> *"Prescribers, pharmacists and other allied healthcare professionals each have important roles in a patient's treatment with pharmacotherapy. Good communication between all parties is essential to maximise the benefits of pharmacotherapy. Treatment goals and decisions should be discussed and agreed upon by all health professionals and with the patient. Responsibility of providing safe clinical care is shared equally among all healthcare professionals involved in the care of a patient"*

While the principle espoused herein of sharing responsibility for safe clinical care is laudable, the Policy appears to lack practical guidance for how to achieve this. In particular, there does not appear to be any guidance to assist a doctor who is providing non-ORT care for a patient who is being treated separately with ORT by another doctor. I imagine these 'non-ORT' doctors must have a large number of questions. For example, how do I find out if my patient is receiving ORT? How do I find out who the ORT prescriber is? What do I need to know about my patient's ORT treatment when I am considering prescribing a drug? What pharmaceutical drugs are commonly sought by ORT patients and how do I identify drug-seeking behaviours? When should I contact the ORT doctor to provide or seek information about the patient? It is not always wise to rely on the information provided by the patient in this regard.

I understand that the Victorian Department of Health has convened its Advisory Group for Drugs of Dependence to consider issues relating to methadone prescribing and dispensing that have recently been highlighted by several Victorian coroners (see list in paragraph 25 a above). This would appear to be a good opportunity for the Victorian Department of Health to seek expert advice on whether guidelines should be drafted to assist doctors (other than ORT providers) who are treating ORT patients.

RECOMMENDATION RE:ORT CO-ORDINATION

That the Victorian Department of Health seek advice from the Advisory Group for Drugs of Dependence, regarding whether guidance should be produced to assist doctors who treat ORT clients for conditions other than opioid dependence. Particular areas of guidance might include how and when to communicate with the patient's ORT provider, pharmaceutical drugs that can interact with the drugs prescribed in ORT, and warning signs that the patient might be becoming unstable in ORT (and what to do if these warning signs are identified).

I DIRECT that a copy of this Finding and Recommendations be provided to the following:

- The Family of Paul Kanis
- Rural Doctors Association of Victoria Secretariat, PO Box 75, Mount Beauty VIC 3699
- Australian College of Rural and Remote Medicine, National Office, GPO Box 2507, Brisbane 4001

- Dr Pradeep Philip, Secretary, Department of Health
- Mr Matthew McCrone, Department of Health
- The Hon. Jill Hennessy, Victorian Minister for Health
- Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, 211 Victoria Parade, Collingwood 3066
- Dr B Rooney
- Dr Daryl Ham, Hillcrest Family Medicine, 26 Seymour Street, Traralgon 3844
- Dr Cameron Loy, 6 Bowlers Avenue, Geelong West 3218
- The Secretary, Royal Australasian College of General Practitioners. 100 Wellington Parade, East Melbourne 3002

Signature:

JACINTA HEFFEY
CORONER
Date: 17 December 2014