IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006924

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Kim Marie Bartolo
Date of birth:	9 October 1974
Date of death:	26 December 2021
Cause of death:	1a : MIXED DRUG TOXICITY (VENLAFAXINE, DULOXETINE, MIRTAZAPINE, OXYCODONE, TAPENTADOL, BENZODIAZEPINES) 2 : HYPERTENSIVE HEART DISEASE
Place of death:	12 Brighton Place, Craigieburn, Victoria
Keywords:	Mixed drug toxicity – prescription medication – discharge summary

INTRODUCTION

1. On 26 December 2021, Kim Marie Bartolo was 47 years old when she passed away at home. At the time of her death, Kim lived in Craigieburn, with her mother Sylvana Bartolo. She is also survived by her daughter, Georgia.

BACKGROUND

2. Kim's medical history included asthma, chronic obstructive pulmonary disease, chronic liver disease, high cholesterol, hypertension, Wernicke encephalopathy, anxiety and depression. She also had a history of alcohol abuse and illicit drug use. Kim was prescribed medication including venlafaxine, diazepam, temazepam, mirtazapine and duloxetine.

3. On 9 October 2021, Kim was admitted to the Brunswick Private Hospital (**BPH**) after sustaining a fractured hip in a fall at home. She had initially been treated at the Northern Hospital. In addition to the treatment of her physical injury, Kim was reviewed by a Consultant Psychiatrist who diagnosed her with Persistent Depressive Disorder and Alcohol Use Disorder. The psychiatrist introduced an alternative medication regime which involved gradually replacing her venlafaxine prescription with duloxetine and her diazepam prescription with oxazepam. He discussed and explained this cross-titration process with Kim, whom he assessed to have decision-making capacity.

4. Kim was discharged from BPH on 5 November 2021. A comprehensive medication list was provided to her at this time with a further copy for her General Practitioner (**GP**). The hospital pharmacist also explained the list to Kim. BPH stated that a discharge summary was also faxed to her GP.

5. Kim had telehealth appointments with her GP on 9 November and 7 December 2021. He stated that he had not been provided with a discharge summary from BPH or a medication list from Kim's pharmacy. After checking SafeScript and consulting with Kim, the GP prescribed medication including tapentadol, oxycodone, mirtazapine, oxazepam, temazepam, venlafaxine and duloxetine.

6. The cross-titration process for Kim's medication regime, which had been introduced by the Consultant Psychiatrist at BPH, was clearly explained to her before her discharge from hospital but it was not recorded in the discharge summary, nor communicated to her GP by BPH.

THE CORONIAL INVESTIGATION

7. Kim's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Kim's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into Kim's death including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. In the evening on 25 December 2021, Kim telephoned "My Emergency Doctor" and spoke with a medical practitioner. Kim was unable or unwilling to speak with the doctor so he obtained a history from her mother. Ms Bartolo reported that Kim had been unwell recently with headache and nausea. The doctor provided a script for ondansetron for her nausea and

[1] 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.

recommended oral fluids. He also advised that Kim go to the Emergency Department if her condition worsened. He offered to call an ambulance, which was declined, and otherwise advised that Kim visit her GP on 27 December 2021.

13. On 26 December 2021 at around 10.00am, Ms Bartolo observed Kim to be sleeping on the couch. At around 1.40pm, Ms Bartolo unsuccessfully tried to rouse Kim and then sought the assistance of neighbours. Emergency services were contacted and cardiopulmonary resuscitation (**CPR**) was commenced. Ambulance Victoria arrived at around 1.53pm but Kim was unable to be revived and was pronounced deceased by paramedics.

Identity of the deceased

14. On 26 December 2021, Kim Marie Bartolo, born 9 October 1974, was visually identified by her mother, Sylvana Bartolo.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine performed an autopsy on 4 January 2022 and provided a written report of her findings dated 6 April 2022.

17. Dr Fronczek observed that the heart was enlarged, which was considered a contributing factor to death. She did not identify any injuries which may have caused or contributed to death.

18. Toxicological analysis of post-mortem samples identified the presence of tapentadol, oxycodone, venlafaxine, diazepam, temazepam, oxazepam, mirtazapine and duloxetine. Dr Fronczek noted that venlafaxine and duloxetine were detected at toxic levels. She stated that the combination of drugs in the system can lead to depression of the central nervous and respiratory systems.

19. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) Mixed drug toxicity (venlafaxine, duloxetine, mirtazapine, oxycodone, tapentadol, benzodiazepines).

20. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Kim Marie Bartolo, born 9 October 1974;

    b) the death occurred on 26 December 2021 at 12 Brighton Place, Craigieburn, Victoria, from mixed drug toxicity (venlafaxine, duloxetine, mirtazapine, oxycodone, tapentadol, benzodiazepines); and

    c) the death occurred in the circumstances described above.

22. Having considered all of the circumstances, I am satisfied that Kim's death was the unintended consequence of her deliberate consumption of prescription medication.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. That Brunswick Private Hospital review its procedures and processes in relation to the formulation and communication of discharge summaries to ensure that they include all relevant information relating to the treatment of a patient arising from the admission (including medication requirements relating to any mental health treatment) and that they are promptly communicated to the patient's General Practitioner.

I convey my sincere condolences to Kim's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Rosanna Tabone, Senior Next of Kin

Kylie Tabone, Senior Next of Kin

My Emergency Doctor

Brunswick Private Hospital

Avant Law

Sergeant David Barlow, Coroner's Investigator

Signature:

Coroner David Ryan

Date: 20 January 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.