OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Bradley John Muller**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Toowoomba
FILE NO:	TOOW-COR-00000120/08
DELIVERED ON:	9 June 2010
DELIVERED AT:	Toowoomba
HEARING DATES:	24 & 25 February 2010 and 12 April 2010
FINDINGS OF:	Coroner Kay Ryan

CATCHWORDS: CORONERS: Inquest – Doctor shopping – Pharmacies filling prescriptions – Seroquel (Quetiapine) overdose – Hospital accident & emergency response

REPRESENTATION:

Sergeant A Costa appearing to assist the Coroner

Mr A Luchich of Counsel instructed by Guild Lawyers for Gatton Pharmacy, Vaughan's Plaza Pharmacy & Lockyer Valley Pharmacy.

Ms M Callaghan of Counsel, instructed by Flower & Hart, representing Doctors Smit, James and Margolis

Ms K Forrester of Counsel appearing for Wendy Lorenzen, Registered Nurse.

BRADLEY JOHN MULLER

INQUEST 24, 25 FEBRUARY & 12 APRIL 2010
TOOWOOMBA CORONER'S COURT

FINDINGS

Contents

CORONERS FINDINGS AND DECISION

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of Bradley John Muller. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

1. Introduction

The purpose of an inquest is to investigate a death to enable the Coroner to find

(a) who the deceased person is;
(b) how the person died;
(c) when the person died;
(d) where the person died; and
(e) what caused the person to die.

The scope of my findings do not include, and indeed I am unable to find under the *Coroners Act 2003*, whether any person is guilty of an offence or is civilly liable for something. I can, however, where appropriate, comment on anything connected with a death which has been investigated and which relates to –

(a) public health or safety;
(b) the administration of justice; or
(c) ways to prevent deaths from happening in similar circumstances in the future.

At the outset, I extend my personal condolences to Mr Muller and his family and trust that these proceedings have assisted in their grieving process following Bradley's death.

2. Issues

I have identified the following issues which were addressed at the formal inquest:

- what procedures were in place to check whether Mr Muller had been prescribed the same drugs by other doctors;

- what procedures were in place to ensure that the same or different pharmacists did not fill the same (or similar) prescriptions for Mr Muller within a short period of time;

- what procedures were taken by the Gatton Hospital to assist Mr Muller when he attended on three occasions in the early hours of the morning of his death seeking assistance;

- why was Mr Muller turned away by Gatton Hospital when he advised that he had taken numerous tablets.

3. Social History

Bradley Muller was a single man aged 45 years and was unemployed. He had had a troubled past with a history of mental health issues. He had been discharged from the Acute Psychiatry Unit at Toowoomba Base Hospital on 5 December 1997. Then on 14 April 1998, he was transferred to Toowoomba Base Hospital from Gatton Hospital having taken an overdose of Prothiaden tablets. Following treatment in the Acute Psychiatric Unit at Toowoomba Base Hospital, he was transferred to Baillie Henderson Hospital for further inpatient treatment.

There were two further admissions to the Acute Psychiatric Unit at Toowoomba Base Hospital in 1998, one to Baillie Henderson Hospital and one to Gatton Health Services. He then was under the auspices of the Gatton Community Mental Health Service.

Mr Muller moved to the Gold Coast at one stage and then to Eulo where he was apparently working. He became noncompliant with his medications. There followed a history of admissions to Ipswich, Gatton, Gold Coast, Cunnamulla and Toowoomba Hospitals.

Mr Muller had a history of overdosing on prescription medications, some of which were very serious. Following is a list of overdoses taken from the submissions made by Ms Callaghan of Counsel –

• 14 April 1998	30 - 75mg Prothiaden
• 12 June 1998	6 - 2mg Valium
• 22 November 1998	16 - 5mg diazepam
• 7 December 1998	60 Cogentin
• 12 June 1999	50 - 2mg Risperidone
• 29 November 1997	intoxicated and threatening suicide by crashing his car
• 18 January 2008	“wanting to overdose because no-one takes him seriously”
• 19 January 2008	alleged overdose of 10 - 200mg quetiapine and 10 - 200mg amisulphide
• 22 January 2008	100 - 5 mg diazepam, 20 - 200mg quetiapine and 20 - 200mg amisulphide

- 24 January 2008 — after discharge took 150 diazepam, 20 - 200mg quetiapine, 20 - 200mg amisulphide and 12 stubbies of beer
- 26 January 2008 — Aspirated in Emergency Department and was ventilated in ICU.

Medical records were not obtained from Ipswich, Gold Coast and Cunnamulla, but it was accepted that Mr Muller had a history of numerous overdoses.

His father says he had been depressed since his mother's death in about 2000. However, it appears that he had been suffering from schizophrenia for some considerable time and was not always compliant with his medications. Mr Muller and his brother Shaun moved in with their father at 32 Highview Avenue, Gatton at the beginning of 2008.

4. The Incident

On the night of 31 October 2008, Mr Bradley Muller and his brother Shaun Muller went to the Royal Hotel at Gatton to play the pokies and for a few drinks. Mr Bradley Muller had about three beers and around midnight left the Royal Hotel and walked with his brother to the Imperial Hotel. Shaun went off and played pool with other people he knew, but saw Bradley on a few occasions playing the pokies. When Shaun left the Imperial Hotel around 2.00am he did not see Bradley and thought he must have gone home.

When Shaun arrived home, Bradley was not there and his car was gone. Shaun went to the kitchen to prepare some food to eat. Sometime later Bradley came home. Shaun asked him where he had been, but Bradley did not say, simply saying *"I'm tired. I'm going to bed. See you in the morning."*

Mr Edwin Muller, Bradley's father heard him come home and speak to Shaun and also heard him go into his bedroom. Neither Mr Edwin Muller nor Shaun noticed anything out of the ordinary in Bradley's behaviour.

After leaving the Imperial Hotel, Bradley had attended the Gatton Hospital on three occasions – at 1.30am, 2.45am and 3.00am. He did not tell either his brother or his father this.

The following morning (1 November 2008) at around 7.30am, Mr Edwin Muller found Bradley lying fully clothed on the floor of his bedroom not moving. He called Shaun who had to squeeze into the bedroom as Bradley's body was against the door. He found that Bradley was cold and unresponsive. Shaun called 000 and was given instruction by the operator to check his airways. When he rolled Bradley over, he saw that the side of his face was purple and that Bradley had been dead for a while.

Paramedic Anthony Clark who attended completed a Life Extinct form at 8.07am.

At autopsy, Dr Roger Guard found the cause of death to be an overdose of Quetiapine (*Seroquel*) augmented by alcohol.

5. Doctors' consultations

Police attended at 32 Highview Avenue, Gatton to undertake an investigation into the death and found numerous packets of prescription medication stored in a bookcase in Bradley's room. They also found empty blister packs of *Seroquel* medication in the footwell of Bradley's car.

A review of the packets of medication indicated that Bradley had consulted a number of different medical practitioners to obtain prescriptions and then had these prescriptions filled at a number of different pharmacies located in the Lockyer Valley area.

Ms Callaghan of Counsel who appeared for Drs James, Smit, Margolis and Obinwanor helpfully provided a chronology of consultations with doctors, subsequent dispensing of the medication *Seroquel* and presentation at Gatton Hospital which I have reproduced (with cosmetic alteration) as appendix 1.

From that chronology, it would appear that Bradley consulted Dr Margolis of the Royal Flying Doctor Service when he was resident at Eulo, to obtain an authority script for *Seroquel*, as the Eulo Medical Service had given a standard (non authority) script.

An authority script is one which is authorised by the Federal Government to enable patients to access expensive medications at a reduced cost. The authority does not have anything to do with the potential for a drug to be abused or "doctor shopped" such as benzodiazapines and other opiate drugs.

The evidence reveals that Dr Margolis made enquiries of the Eulo Clinic and obtained a copy of Bradley's medical records before prescribing the authority script for *Seroquel* 300mg bd.

Dr Margolis' evidence was helpful in that he explained that the normal dose range for long term use of *Seroquel* was between 150mg and 750mg per day. He stated that the drug works on multiple different places in the brain and it was not uncommon for it to be prescribed, as here, in 200mg and 300mg doses, for mental health disorders such as schizophrenia.

Bradley then saw Dr James on 2 November 2007 at the Lowood Medical Centre requesting repeat medications as he was visiting from Eulo and was running low on medications. He only saw Dr James on the one occasion. It would appear that Dr James originally prescribed *Seroquel*

200mg three times a day, which was dispensed to Bradley on the same day by Lowood Pharmacy as *Seroquel* 300 mg.

Dr James' evidence is that he probably provided authority to the pharmacist by telephone for the 300mg script as this correlated with Bradley's previous prescriptions. He did not note this in his records.

Bradley then saw Dr Obinwanor once on 24 December 2007 and was prescribed Quetiapine 200mg. This was dispensed on the same day at the Gatton Pharmacy.

Bradley was then reportedly suicidal during January 2008 having presented on 4 occasions to the Ipswich General Hospital with suicidal thoughts and overdoses. He was admitted to the Princess Alexandra Hospital having taken an overdose.

Bradley returned to Gatton and consulted with Dr Smit with a lung infection following his overdose. He was appropriately treated. Subsequently, Bradley saw Dr Smit and then Dr Moodley (at Dr Smit's practice) who increased the dose of *Seroquel* 200mg i nocte previously prescribed by Dr Smit.

Bradley then consulted Dr Singh for further prescriptions on 1 May 2008. At this time he denied "any suicidal/homicidal delusions". He was further prescribed *Seroquel* 200mg ii nocte. Bradley continued to see Dr Smit, Dr Singh and a Dr Thorpe for other ailments, last consulting with Dr Ellepola on 31 October 2008 for vomiting and haematemesis.

All prescriptions for *Seroquel* 200mg and 300mg were dispensed in packets of 60 tablets – enough for a month's supply. Each doctor issued a prescription with a number of repeats – the most usual being 6 repeats. This would equate to a supply of medication for a period of 7 months.

A perusal of the chronology shows that he saw different doctors in the year prior to his death seeking prescriptions for *Seroquel*. Those consultations occurred in October 2007 (Dr Margolis), November 2007 (Dr James), December 2007 (Dr Obinwanor), February 2008 (Dr Smit) and May 2008 (Dr Singh).

Drs Margolis, James, Obinwanor and Smit state they did not have access to Bradley's extensive medical records – even though Bradley sought treatment from Dr Smit for a lung infection following an overdose in early 2008 for which he was treated at the Ipswich General Hospital.

6. Pharmacy procedures

It has been established that Bradley was prescribed quantities of *Seroquel* 200mg and 300mg over an extended period of time and had those

prescriptions filled at four different pharmacies located in the Lockyer Valley.

A table of these prescriptions and their dispensing is attached as Appendix 2.

An examination of the table reveals that whilst Bradley was dispensed both *Seroquel* 200mg and *Seroquel* 300mg by different pharmacies in the Lockyer Valley at a frequency of much less than a month, none of the pharmacists became concerned as Bradley only visited the same pharmacy to have his medications dispensed once the appropriate time had expired.

For example, he was dispensed *Seroquel* 200mg and 300mg by the Lowood Pharmacy on 14 December 2007, returning to that pharmacy on 14 January 2008 for a further prescription to be dispensed. It is noted however that he had also attended the Gatton Pharmacy on 24 December 2007 to have *Seroquel* 200mg dispensed.

Further examples occurred in March and April 2008 when Bradley was dispensed *Seroquel* 200mg at the Gatton Pharmacy on 13 March 2008, *Seroquel* 200mg at Vaughan's Plaza Pharmacy on 19 March 2008, the same prescription dispensed by Lockyer Valley Pharmacy on 31 March 2008 and again by Vaughan's Plaza Pharmacy on 19 April 2008 and Gatton Pharmacy on 24 April 2008.

I note there is an exception to this where he had *Seroquel* 200mg and 300mg dispensed from the Lowood Pharmacy on 2 November 2007 and again on 23 November 2007, some 3 weeks apart. Given that this period was close on the one month, the pharmacist was not alerted to anything being amiss.

A further exception occurred in August 2008 when Bradley was dispensed the last three repeats of the prescription from Dr Smit by Vaughan's Plaza Pharmacy.

The pharmacist involved, Ms Kiers, gave evidence that Bradley had asked for the prescriptions to be dispensed because he was going to work in a mine near Mt Isa and would find it difficult to fill the prescription. Ms Kiers states that she conferred with her fellow pharmacist Mr Alex Hood, and then agreed to Bradley's request. She stated that it was not uncommon for customers to seek the dispensing of medication for a longer period when they were going away for a long period of time.

She agreed that Bradley was unemployed at the time, but believed what he told her – that he had found work in the mines. When questioned, Ms Kiers agreed that Bradley had 'some sort of pension card', but had not noted whether it was a disability pension card or some other type of health card.

None of the pharmacists knew about the other prescriptions dispensed, as there is no protocol in place to warn pharmacists when similar prescriptions are dispensed to the same patient on the same day or within a short period of time. Further, Bradley appeared to produce prescriptions from the same doctors to each of the pharmacies, so they were also not aware that he had consulted different doctors to obtain the prescriptions.

There is no evidence before me to indicate why Bradley undertook this practice. It may well have been the case that he was stockpiling the medications (as is apparent from the cache stored in his bedroom), but for what purpose remains unclear.

Evidence before me revealed that pharmacists are unable to dispense the same prescription more than once on one day. For example, a pharmacist is unable to dispense two prescriptions for *Seroquel* 200mg on the one day, but can dispense one prescription for *Seroquel* 200mg and one prescription for *Seroquel* 300mg on the one day.

Seroquel is not a drug of addiction and has not been recognised as a drug which would be the subject of "doctor shopping". Product information for *Seroquel* reveals that a lethal dose could be as low as 13g. It is dispensed in packets of 60 tablets each, meaning that ingestion of one packet of 300mg *Seroquel* could be sufficient to cause death.

7. Gatton Hospital Procedures

The Gatton Hospital Records were obtained during the investigation and these were tendered at the inquest as Exhibit 28.

The Registered Nurse on duty was Wendy Lorenzen, who also gave evidence.

The medical records revealed that Bradley had attended the Gatton Hospital on three occasions – at 1.30am, 2.45am and 3.00am.

It is prudent to include here the evidence of Nurse Lorenzen with regard to the arrangements at Gatton Hospital for after hours emergencies.

The only staff rostered on after hours is a Registered Nurse and an Enrolled Nurse. A doctor is on call and is located in a unit some 20 metres from the hospital. The door to the Accident and Emergency section is locked and any patients must ring the buzzer at the front door of the hospital to seek attention from the staff.

At 1.30am Bradley presented at the hospital complaining of being unwell for the last 3 to 4 days. Nurse Lorenzen opened the door to the emergency section to let him in. He was nauseated and had been vomiting. Nurse Lorenzen noted on the rural Emergency Flow Sheet that Bradley told her that he saw his GP on Friday when his medication was

changed. He told her that he was suicidal and she noted his medical history to include that he had attempted overdosing “x20 (in last years)”. A further notation appears to have been made in a different ink stating “agrees he is attention seeking”.

Nurse Lorenzen stated in evidence that she added the notation when Bradley agreed that he was attention seeking. Observations were taken and the nurse contacted the doctor on call at 1.45am for authorisation to commence intra venous infusion of fluids. Bradley agreed to the IV.

The medical notes state that Bradley was a known mental health patient and was “verbally aggressive at times”. Nurse Lorenzen told the inquest that she did not refer to the medical notes “at first”, but did read them later.

At about 2.28pm Bradley appeared at the nurse’s desk having removed the IV himself, requesting to go home. He was discharged at that time.

At 2.45am the notes record Bradley as having returned stating he had taken some pills. Nurse Lorenzen states that he rang the buzzer and she went and opened the door. She asked how many pills he had taken and Bradley said he had taken about 10 to 20 pills. The nurse suggested that Accident and Emergency at Toowoomba be called so that Bradley could talk to a mental health doctor. Bradley did not want to do this. The nurse further noted that “conversations with this patient hard as he keeps detracting from initial subject.”

Finally at 3.00am Bradley returned to the hospital, rang the buzzer and stated he had taken more tablets but was unable to tell the nurse how many. He did not wait for Nurse Lorenzen to open the door, but left in his car.

The only time Nurse Lorenzen contacted the doctor on duty (Dr Watts), was to have approval given to administer the IV on Bradley’s initial presentation. Notably, at no stage did she contact Dr Watts for direction with regard to the reported taking of pills.

Nurse Lorenzen told the inquest she really had no independent recollection of Bradley and what had occurred. She also stated that she had not received any training from Queensland Health with regard to dealing with mental health patients and had also never received any training in accident and emergency.

Dr Watts gave evidence that there were no rigid guidelines at the Gatton Hospital to deal with a situation such as presented itself on this occasion. He stated that normally the TACT teams would be contacted as well as the psychiatric registrar at Toowoomba Base Hospital. He did not review the medical notes until 6.00am on 1 November 2008 when he suggested that police be called on Bradley’s next presentation.

8. Current Government Safeguards

Medicare Australia hosts the Prescription Shopping Program which administers the Prescription Shopping Information Service. Under an additional analysis and support function, Medicare has the authority to disclose without consent, specific and limited PBS information to a doctor about their patients who may be getting PBS medicine in excess of medical need.

A doctor must be registered with the Prescription Shopping Information Service. Once registered, a doctor can call the information service 24 hours a day, 7 days a week and find out if their patient has been identified under the Prescription Shopping Program and receive information on the amount and type of PBS medicine recently supplied to that patient.

A prescription shopper is defined as –

> *A person who in any 3 month period has had supplied to them:*
>
> *a. PBS items prescribed by 6 or more different prescribers (excluding specialists and dentists); or*
>
> *b. a total of 25 or more "Target" PBS items (central nervous system drugs); or*
>
> *c. a total of 50 or more of any PBS items.*

I note in this case that only one of the doctors gave evidence that he is registered with the Program, but that Bradley's request for a prescription, did not "alert" him to the extent that he would contact the Information Service. This is because there have been no reported cases of problems, either by overdosing, doctor shopping or death as a result of taking *Seroquel*.

The legislation underpinning the Prescription Shopping Program allows PBS information about a patient to be disclosed to the patient, a prescriber to that patient and an approved supplier to that patient. That is the patient, his/her doctor and the pharmacist dispensing the prescription.

This disclosure complies with the requirements of the *Privacy Act 1988*[1] in that the disclosure is "*required or authorised by or under law*"[2], and the *National Health Act 1953* in that the disclosure is *"in the performance of duties or in the exercise of powers or functions".*[3]

In the course of my investigation, I was advised by Medicare Australia, that whilst the Direction allows patient information to be disclosed to

[1] S95A
[2] IPP 11(1)(d)
[3] S135A(1)

prescribers, patients and "approved suppliers", in practice, information is only disclosed to prescribers and patients.
"This is because of the practical difficulties and privacy issues that would be involved in disclosing information to approved suppliers (for example, in validating supplier identity)."

Further advice was received that Medicare Australia is currently undertaking a review of its Prescription Shopping Program and as part of this will review the barriers to providing information to suppliers.

In any event, Bradley would not have been seen as being a "prescription shopper" as his actions did not fit within the definition. In particular the medication *Seroquel* would not be seen as a "Target" PBS item.

The Pharmacy Guild of Australia introduced a national program to share information about persons obtaining over the counter medicines which may be the subject of abuse or diversion. The program is known as Project STOP. The Project provides a real-time database for recording all requests for products containing pseudoephedrine. All requests for pseudoephedrine-based products are entered into a web-based database. The pharmacist requests photo ID or other proof of identity and is instantly able to verify if a purchase has already been made against that ID and then makes a decision to accept or decline the sale.

Project STOP aims to maintain convenient access to effective cold and flu medicine for legitimate consumers, while restricting access for criminals who would use them to manufacture dangerous illicit drugs.

There is no other program in existence which could warn prescribing medical practitioners and/or pharmacists when a patient is accessing prescription medication at an unacceptable rate.

9. Findings

In accordance with the *Coroner's Act 2003*, I find

(a) The identity of the deceased person is Bradley John Muller.

(b) Bradley died of an overdose of quetiapine (contained in the medication *Seroquel*) in combination with alcohol.

(c) Bradley died on 1 November 2008.

(d) Bradley died at his home at 32 Highview Avenue, Gatton.

(e) Bradley's death was caused by his taking 32 - 300mg tablets of *Seroquel* with alcohol. Whether this was taken deliberately or as a cry for help is unclear. Given the evidence of his brother and father that Bradley seemed to be in good spirits on the night before his death and when he went to bed on the morning of his death, I am

unable to conclude that he took his own life deliberately. Although Bradley obtained a number of prescriptions for *Seroquel* from different doctors and was able to have these prescriptions filled at four different pharmacies, I find that, whilst he was able to stockpile large amounts of medication, this did not directly contribute to his death.

Seroquel 200mg and 300mg is manufactured and supplied in packets of 60 tablets – potentially 12g to 18g. A fatal dose has been reported as being as low as 13.6g of this medication. It would appear from the evidence that Bradley took the equivalent of 9.6g of *Seroquel* with alcohol.

Bradley went to the Gatton Hospital on three occasions in the early morning before his death. He was treated for dehydration on the first occasion, but self discharged himself. He returned twice, reporting that he had taken pills. I find that the inaction of the staff at the Gatton Hospital, and in particular Nurse Lorenzen, when Bradley re-attended contributed to his death.

10. Recommendations

It is recommended that -

(a) the drug *Seroquel* be packaged, marketed and supplied in packets of 30 to protect against lethal doses of the medication being dispensed to vulnerable members of society.

(b) That Queensland Health urgently provide –

(i) full training in emergency and mental health to health professionals staffing regional/rural hospitals after hours;

(ii) a policy for dealing with mental health patients presenting to regional/rural hospitals after hours.

(c) That a national database containing dispensing histories for all patients be developed to enable pharmacists to identify over-dispensing of prescription medication. Such a database should have a facility to raise an alert if the same prescription medication has been dispensed by any pharmacist to the same patient within a short period of time.

(d) To enable this to take place, I further recommend that the Federal privacy laws be amended to enable PBS information about a patient to be disclosed to the approved supplier of medication to that patient.

Kay Ryan
Coroner
9 June 2010

APPENDIX 1

Date	Event
1 August 2007	Prescribed Solian 200mg i daily and Seroquel (quetiapine) 200mg i nocte by doctor at Eulo Clinic.
26 September 2007	Deceased attended Eulo clinic and saw unknown doctor - noted that deceased had anxiety and borderline personality but no record of prescription.
29 September 2007	Teleconsultation with Dr Stephen Margolis of RFDS. Deceased requested authority script for Seroquel as given standard (non authority) script by Eulo clinic. Dr Margolis sought copies of the Eulo Clinic records.
1 October 2007	Dr Margolis phoned the deceased and advised that he had been given a script for Seroquel 200mg on 1 August 2007. Deceased told Dr Margolis that was now onSeroquel 300mg bd but had lost that script. Dr Margolis provided an authority script for Seroquel 300mg bd.
2 November 2007	Deceased consulted Dr Ronald James at Lowood Medical Centre (LMC)- said that he was residing at Eulo and requested repeat medications - given Solian 30mg I daily and Seroquel 200mg i tds.
2 November 2007	Deceased dispensed quetiapine 300mg 60 at Lowood Pharmacy (Dr Margolis 1/6).
2 November 2007	Deceased dispensed quetiapine 200mg at Lowood Pharmacy (Dr James 1/6)
23 November 2007	Deceased dispensed quetiapine 300mg 60 at Lowood Pharmacy (Dr Margolis 2/6)
23 November 2007	Deceased dispensed quetiapine 200mg at Lowood Pharmacy (Dr James 2/6)

14 December 2007	Deceased dispensed quetiapine 300mg 60 at Lowood Pharmacy (should be Dr Margolis 3/6)
14 December 2007	Deceased dispensed quetiapine 200mg at Lowood Pharmacy (Dr James 3/6)
24 December 2007	Deceased prescribed quetiapine 200mg by Dr Obinwanor.
24 December 2007	Deceased dispensed quetiapine 200mg 60 at Gatton Pharmacy (Dr Obinwanor 1/6).
14 January 2008	Deceased dispensed quetiapine 200mg 60 at Lowood Pharmacy (Dr Obinwanor 2/6).
18- 24 January 2008	Four presentations/admissions to Ipswich General Hospital with suicidal threats and/or alleged overdoses.
25 January 2008	PAH Division of Mental Health assessment faxed to Gatton Plaza on 6 March 2008 - "multiple overdoses over the years - previous ICU admissions.....Dr shops for medications - states that he has a lot of medications stock piled". The deceased apparently caught a taxi from Ipswich after being refused admission. After review and discussion with Dr Doug Scott, Director of Ipswich Mental Health Services, the deceased was kept in the Emergency Department - nursing staff recorded "chose to leave at 21.30 stating that he would "get a bed somehow".
26 January 2008	Princess Alexandra Hospital (PAH) chest x-ray report indicates that deceased was intubated after further overdose.
12 February 2008	Deceased consulted Dr Smit with lung infection post overdose -treated with antibiotics.
20 February 2008	Deceased consulted Dr Smit (GP)- "stress/ insomnia Rambling ++"

	Dothiepine 25 mgs1-2 nocte added to drug regime.
28 February 2008	Deceased consulted Dr Smit (GP) – given script for Solian 200 i nocte, Seroquel 200mg i nocte.
28 February 2008	Deceased dispensed quetiapine 200mg 60 at VO Vaughan Chemist (Dr Smit 1/6).
10 March 2008	Deceased consulted Dr Nemalan Moodley (GP) - given script for Seroquel 200mg ii nocte as increased dose from iii nocte.
13 March 2008	Dispensed quetiapine 200mg at Gatton Pharmacy (Dr Obinwanor 3/6)
17 March 2008	Deceased consulted Dr Nemalan Moodley (GP) - for CT liver as US showed possible liver cyst.
19 March 2008	Dispensed quetiapine 200mg 60 at VO Vaughan Chemist (Dr Smit 2/6)
31 March 2008	Dispensed quetiapine 200mg 60 at Lockyer Valley Pharmacy (Dr James 4/6).
19 April 2008	Dispensed quetiapine 200mg 60 at VO Vaughan Chemist (Dr Smit 3/6)
24 April 2008	Dispensed quetiapine 200mg 60 at Lockyer Valley Pharmacy (Dr James 5/6).
24 April 2008	Dispensed quetiapine 200mg 60 at Gatton Pharmacy (Obinwanor 4/6)
24 April 2008	Dispensed quetiapine 300mg 60 at Lockyer Valley Pharmacy (Dr Margolis 5/6)
1 May 2008	Deceased consulted Dr Paramijit Singh (GP)- "wants scripts..denies any suicidal/homicidal delusions" Given script for Seroquel 200mg ii nocte and Solian 200mg i nocte.

7 August 2008	Dispensed quetiapine 200mg 60 at Gatton Pharmacy (Dr Obinwanor 5/6).
7 August 2008	Dispensed quetiapine 200mg 60 at Lockyer Valley Pharmacy (Dr James 6/6).
7 August 2008	Deceased dispensed quetiapine 300mg 60 at Lockyer Valley Pharmacy (Dr Margolis 6/6)
7 August 2008	Dispensed quetiapine 200mg 60 at VO Vaughan (Dr Smit 4/6).
8 August 2008	Dispensed quetiapine 200mg 60 at VO Vaughan (Dr Smit 5/6).
11 August 2008	Dispensed quetiapine 200mg 60 at VO Vaughan (Dr Smit 6/6).
14 August 2008	Deceased consulted Dr Singh (GP) – for sexually transmitted infection screen.
20 August 2008	Deceased consulted Dr Singh (GP) who explained the pathology test results (all negative).
20 September 2008	Deceased consulted Dr Thorpe (GP) "requests medication as per letter IGH mental health" - Solian 200mg I bd, Valium 5mg I prn.
7 October 2008	Deceased consulted Dr Smit (GP) for bilateral painful feet and given Codalgin Forte.
8 October 2008	Dr Smit prescribed anti-inflammatory, Fenac - described deceased as "verbacious".
16 October 2008	Dr Smit prescribed Valium 5mg I prn.**
17 October 2008	Dispensed quetiapine 200mg 60 (Dr Obinwanor 6/6).
31 October 2008	At 1.27pm, the deceased consulted DrEllepola with vomiting and haematemesis - diagnosed gastritis and prescr¡bed Amoxyl and Motilium. Advised not to smoke or drink alcohol.

31 October 2008	Dispensed quetiapine 200mg 60 at VOVaughan (Dr N Moodley 1/6).
31 October 2008	At around 9.50pm, the deceased went to the Royal Hotel with his brother Shaun and consumed at least three "beers" before midnight when they went to lmperial Hotel.
1 November 2008	1.30am presented to Gatton Hospital - stated that suicidal. Assessed by RN Lorenzen -tongue dry. She phoned Dr W Watts who ordered lV fluid 1 litre. Deceased removed cannula and went home at 2.28am. Deceased returned at 2.45am saying he had taken some pills 10-20. Deceased returned again to Gatton Hospital at 3.00am saying he had taken more tablets, was unable to say how many and left.
1 November 2008	2.30am Shaun Muller recalled that the deceased returned home.
1 November 2008	7.30am the deceased found dead by brother Shaun.

APPENDIX 2

BRADLEY MULLER

SEROQUEL DISPENSED

Date	Pharmacy Dispensing	Doctor Prescribing	Medication	Strength	No. of Tablets
Not filled	Gatton Pharmacy	Dr P Singh	Seroquel	200 mg	60
22.10.07	Lowood Pharmacy	Dr M	Seroquel	200 mg	60
02.11.07	Lowood Pharmacy	Dr S Margolis	Seroquel	300 mg	60
02.11.07	Lowood Pharmacy	Dr R James	Seroquel	200 mg	60
23.11.07	Lowood Pharmacy	Dr S Margolis	Seroquel	300 mg	60
23.11.07	Lowood Pharmacy	Dr R James	Seroquel	200 mg	60
14.12.07	Lowood Pharmacy	Dr R James	Seroquel	300 mg	60
14.12.07	Lowood Pharmacy	Dr R James	Seroquel	200 mg	60
24.12.07	Gatton Pharmacy	Unknown	Seroquel	200 mg	60
14.01.08	Lowood Pharmacy	Dr C Obinwanor	Seroquel	200 mg	60
28.02.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Win	Seroquel	200 mg	60
13.03.08	Gatton Pharmacy	Unknown	Seroquel	200 mg	60
19.03.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Win	Seroquel	200 mg	60
31.03.08	Lockyer Valley Pharmacy	Dr R James	Seroquel	200 mg	60
19.04.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Win	Seroquel	200 mg	60
24.04.08	Gatton Pharmacy	Unknown	Seroquel	200 mg	60
24.04.08	Lockyer Valley Pharmacy	Dr S Margolis	Seroquel	300 mg	60
24.04.08	Lockyer Valley Pharmacy	Dr R James	Seroquel	200 mg	60
01.08.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Smit	Seroquel	200 mg	60
07.08.08	Lowood Pharmacy	Dr C Obinwanor	Seroquel	200 mg	60
07.08.08	Gatton Pharmacy	Dr C Obinwanor	Seroquel	200 mg	60
07.08.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Smit	Seroquel	200 mg	60
07.08.08	Lockyer Valley Pharmacy	Dr S Margolis	Seroquel	300 mg	60
07.08.08	Lockyer Valley Pharmacy	Dr R James	Seroquel	200 mg	60
08.08.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Smit	Seroquel	200 mg	60

11.08.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr Smit	Seroquel	200 mg	60
17.08.08	Gatton Pharmacy	Dr C Obinwanor	Seroquel	200 mg	60
17.10.08	Gatton Pharmacy	Dr C Obinwanor	Seroquel	200 mg	60
31.10.08	V.O. Vaughan, Gatton (Vaughan's Plaza Pharmacy)	Dr N Moodley	Seroquel	200 mg	60