QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# NON-INQUEST FINDINGS

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| CITATION: | **Investigation into the death of Rachel Danielle SMITH** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Southport |
| FILE NO(s): | 2012/2563 |
| FINDINGS OF: | Mr James McDougall, Coroner, South Eastern Region |
| CATCHWORDS: | CORONERS: codeine, oxycodone, 'doctor-shopper', Prescription Shopping Program Alert Service |

Rachel Danielle Smith was 25 years old. She resided with her husband, Elias and her daughter.

Rachel suffered from chronic migraines, depression, type 2 diabetes mellitus, obesity and asthma. She also had a history of chronic sinusitis and chronic cholecystitis for which she had undergone a cholecystectomy (gall bladder removal) and a sinus operation.

Since the birth of her daughter, who was at the time of death three years old, her migraines increased significantly. She had been taking Panadeine Forte since 2001 for headaches and after the birth of her daughter in 2005 she started taking strong addictive painkillers such as oxycodone (Endone), intermittently. At about this time Rachel started seeing multiple doctors to obtain her medications. By 2008 she was regularly attending three different surgeries and occasionally a fourth doctor's surgery to obtain prescriptions for medication.

On 27 December 2008, Elias reported that Rachel had been suffering from one of her usual migraines. She had taken a number of medications including Panadeine Forte, tramadol (Tramal), oxycontin (Oxycontin SR), diazepam (Valium), amitriptyline (Endep) and zolpidem (Stillnox) at about 9am, 12pm and 9pm.

At about 10.30pm Elias had a shower and went to bed and Rachel sat on the floor at the right hand side of the bed using her laptop. At about 1am on 28 December 2008, Elias woke to find Rachel crouched down on the floor with her head in a towel. The computer was still on and had been placed on the bed. Elias checked on Rachel and found her to be unresponsive. He called an ambulance and began resuscitation attempts. Ambulance officers arrived a short time later and were unable to revive Rachel and declared life extinct at 1.29am on 28 December 2008.

An autopsy was conducted on 29 December 2008 which included a toxicological analysis. Analysis of Rachel's blood found the following drugs to be present in her system:

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| 1. | Diazepam | 0.2 mg/kg |
| 2. | Nordiazepam (metabolite) | 0.6 mg/kg |
| 3. | Oxazepam (metabolite) | <0.01 mg/kg |
| 4. | Temazepam (metabolite) | 0.01 mg/kg |
| 5. | Morphine | 0.26 mg/kg |
| 6. | Codeine | 0.31 mg/kg |
| 7. | Total morphine (metabolite) | 0.32 mg/kg |
| 8. | Amitriptyline | 1.1 mg/kg |
| 9. | Nortriptyline (metabolite) | 0.26 mg/kg |
| 10. | Oxycodone | 0.66 mg/kg |
| 11. | Tramadol | 1.4 mg/kg |
| 12. | Zolpidem | 0.27 mg/kg |
| 13. | Paracetamol | 10 mg/kg |

Rachel's urine also tested positive for opiates such as morphine and oxycodone and benzodiazepines such as diazepam.

The pathologist commented:

"*Morphine is a known metabolite of codeine. However, the relatively high morphine when compared to codeine indicated that morphine might be independently taken apart from being a metabolite of codeine. Codeine could be derived from Panadeine Forte, one of the medications that she was taking as described in the police form 1. The high codeine/paracetamol ratio indicated the possibility that codeine could be*

*independently taken as well. The possibility of some these drugs being accumulated over time to toxic levels cannot also be completely ruled out."*

The autopsy report confirmed, and I find, that Rachel Danielle Smith died on 28 December 2008 at Eagleby and the cause of death was mixed drug toxicity.

Elias gave two accounts to the police regarding Rachel Smith's health and drug taking.

On 28 December 2008 Elias stated that his wife had a history of chronic migraines and had been having particularly bad headaches in the week prior to her death. He stated that she had been off oxycodone for two years but had restarted three days before to get through the holidays (as it was Christmas time). He stated that on 27 December 2008 Rachel had consumed two Panadeine Forte, Tramadol SR 100mg, Tramadol 50mg, Oxycodone SR 60mg and Diazepam 10mg at 9am, 12pm and 9pm. In addition she had taken Zolpidem CR 12.5mg at 12pm and Amitriptyline 150mg at 9pm as she had a migraine. Elias also told police that Rachel had a history of depression which had been worse in the preceding two months and had cut her own wrists on two occasions. He told police that she had apparently sought help from a doctor at Eagleby Medical Centre the first time and Loganholme Medical Centre the second time.

On 12 July 2013, Elias Smith gave another statement to police in which he told police Rachel suffered from daily intense migraines. He said that she saw frequent multiple different doctors. He was concerned about the amount of medication she was taking but couldn't recall any of the names apart from Oxycontin and Stillnox. He became aware that she was seeing doctors without his knowledge and getting medications from them. One of those was at Windaroo Practice and she also saw a doctor at Eagleby just before Christmas. He said he discussed with Rachel about better ways to control her pain and she did attend a hypnotherapist (which worked for a few weeks), homeopaths and neurologists. Elias said he made an effort to control the medications he knew about by keeping them in a special place. This was not a secured site and she could access the medication but he would be aware if that happened and he stated that it did not happen too often. Elias was Rachel's carer but he was in full time employment and whilst he was at work, she "doctor-shopped". He knew about most of the doctors she saw but not all of them.

I caused investigations to be made to discover the names of all of the doctors Rachel attended to obtain medication. I had these medical records reviewed by the Forensic Medical Officer at the Clinical Forensic Medicine Unit.

I do not propose to report in detail the findings of the Forensic Medical Officer, Dr Mirakian as her investigations are set out in her report. I do note however, that Rachel saw Dr TT on many occasions in the four years leading up to her death. Dr TT referred Rachel to a psychologist in 2006 and also a neurologist at Princess Alexandra Hospital (Dr AW). He also referred her to another neurologist, Dr SR in 2006. Dr TT notes that by mid-2008 Rachel had made no progress in her attempts to reduce her medications and Dr TT referred her back to Dr SR. By late 2008 Rachel reported to Dr TT that she had reduced her medications and was planning to ween off them by December. Dr TT had no idea Rachel was getting medications from other doctors. Rachel told Dr TT and Dr K on several occasions that she was going on trips overseas in order to get scripts for medications to last her up to a month at a time. She told these doctors she was travelling to New Zealand, to Fiji and to Cairns. She took none of these trips and continued to obtain medication from other doctors. She also saw Dr VA and told him she was under the care of Dr SR, Neurologist at PA Hospital. She saw Dr VA intermittently between July 2005 and September 2006 then regularly until 27 December 2008. Dr VA referred her to a number of other

practitioners, Dr PL (Neurologist) and she did not attend, Dr SR (Neurologist), MR (diabetic educator), AH (dietician), KV (podiatrist) and various counsellors.

On 21 November 2007 Dr VA was notified by the Prescription Shopping Information Service (PSIS) that Mrs Smith had consulted other doctors in the previous three months. He discussed this with her and Mrs Smith agreed not to get her scripts from any other doctors. On 26 July 2007 Elias became involved in managing and controlling the medications. Dr VA refused to write further scripts for oxycodone in 2007 until a neurology review was undertaken.

Mrs Smith requested further oxycodone in July 2008 at approximately monthly intervals to prevent attendances at emergency departments. She was warned not to take oxycodone with Panadeine Forte or tramadol. On 24 December 2008 Rachel presented with a letter from a doctor at PA Hospital (Dr H) requesting he prescribe pain medications so he gave her oxycodone 20 mg and 40 mg. She presented again on 27 December 2008 claiming she had not kept any of her medications down due to vomiting and requested more. Her husband was present and confirmed her story so the oxycodone was prescribed again. Dr VA believed Elias was to control the medications.

Neurologist, Dr SR saw Rachel in July 2006 on referral from Dr TT. Dr SR notes that at the first consultation Rachel had been taking increased amounts of Oxycontin for frequent migraine headaches. He advised her to cease the Oxycontin which she did over the next few months and her headaches improved somewhat. Dr SR saw her again in 2008 when Rachel was using a range of medication for her headaches including Panadeine Forte, tramadol, diazepam, zolpidem and amitriptyline. Dr SR suggested she ween herself off these medications under the supervision of her GP. Dr SR did not see Rachel again and he was unaware that she was seeing multiple doctors to obtain prescriptions.

Rachel also attended at Princess Alexandra Hospital outpatients department on seven occasions between 4 April 2005 and 11 July 2006. On 19 July 2005 and 27 September 2005 and 11 July 2006 she attended Dr AR's (Neurologist) clinic for migraines.

Dr Mirakian was asked to answer a number of questions posed by me in relation to the appropriateness of the treatment offered by various doctors who saw Rachel.

Firstly, she was asked:
*Was the prescribing of any addictive prescription drugs appropriate under the circumstances?*

Dr Mirakian comments that chronic headaches and migraines are extremely debilitating and whilst addictive medications are always best avoided there are some circumstances in which addictive medications may be required. She said that Rachel had been referred to hospital on multiple occasions and to a neurologist privately to help with treatment of her headaches. She had tried many medications traditionally used for migraine headaches and found them to be intolerable with side effects or not helpful.

Dr Mirakian comments that after reviewing Dr TT, Dr VA and Dr L, she believed they were making an attempt to minimise Rachel's use of strong opiates such as oxycodone to try and minimise harm whilst struggling to keep the prescriptions of other addictive medications under control as best they could in light of an extremely manipulative patient.

Secondly,

*Was the overuse of prescription drugs by the patient identified by her doctors in a timely fashion?*

Dr Mirakian says that whilst the three doctors mentioned did attempt to counsel Rachel on her excessive use of medications each of them failed to identify that she was using many more tablets than she was stating and ordered that the two month period for each of these doctors that they failed to restrict the number of zolpidem, diazepam and tramadol tablets taken by Rachel. Dr L also gave out excessive amytriptyline tablets. She comments that the number of Panadeine Forte tablets prescribed was also excessive for each of the doctors but that was harder to quantify as Rachel kept changing the amount of tablets she was supposedly taking.

It is of note that there is no indication that any of the three doctors thought about sending Rachel to a pain specialist. The reason for this perhaps is that Rachel was already under the care of a neurologist and her pain was caused by her neurological problem one can assume that the doctors thought that this was the best specialist to address her pain issues. In addition of that Rachel continually reassured her doctors that her usage of medication was reducing. It is apparent from all of the records that Rachel fits the description "doctor-shopper".

Dr Mirakian expressed the following opinion:

*"As with many disasters, there is often multiple reasons that all contribute to the death of an individual. Mrs Smith's death was due to a number of factors including:*

- *Her own behaviour regarding seeking excessive medications with multiple doctors*
- *Her husband 's lack of control over safekeeping and accountability of the medications at home*
- *Her doctor's failure to recognise her repeated requests for medications beyond that which she said she was taking.*
- *The failure of the Prescription Shopping Program Alert Service to identify the excessive number of scripts being obtained and alerting the doctors to his fact, which would have also had alerted them to the fact Mrs Smith was seeking other prescribers."*

I propose to refer these findings and the medical records to the Office of the Health Ombudsman for review; and include the following suggestions for OHO's consideration and appropriate action:

1. That the Prescription Shopping Program be alerted to the fact that their "alert service" failed Mrs Smith.
2. There should be instituted a national computerised pharmacy system which automatically registers a patients prescription as soon as it is dispensed which would alleviate the six week time gap from dispensing until the PSP send out notifications.

**James McDougall**
**South Eastern Coroner**
**26 November 2014**