CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of ES**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2014/2590
DELIVERED ON:	7 February 2017
DELIVERED AT:	Brisbane
HEARING DATE(s):	2 November & 12-14 December 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Death due to multiple drug toxicity, palliative care in the community, adequacy of palliative care support services provided to families, adequacy of supervision and guidance by medical clinicians, death due to multiple drug toxicity, appropriateness of care provided by family and others, whether medications administered to hasten death

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
Counsel for MB:	Mr Shields and Ms White of Peter Shields Lawyers
Counsel for Dr SK:	Ms Callaghan i/b K & L Gates
Counsel for Nurse SA:	Ms S Robb i/b Roberts & Kane Solicitors
Counsel for Hospital:	Mr M Hickey i/b Minter Ellison
Counsel for Metro North HHS:	Mr A Suthers
Counsel for GS:	Mr A Braithwaite i/b Russo Lawyers

Contents

Introduction 1
The investigations 2
Decision to hold inquest and issues for inquest 5
What is palliative care? 6
Autopsy results 9
Expert report of Dr Treasure McGuire 10
The circumstances leading up to the death, including whether medications were administered to the deceased to hasten her death. 13
Evidence of daughter 13
Evidence of son-in-law 16
Evidence of MB, enrolled nurse 17
The evidence of events subsequent to death 19
- First Response Officers 19
- Admissions made by MB to nursing staff 20

Whether the deceased and her family were provided appropriate end of life care support and services following her discharge from the Prince Charles Hospital on 10 July 2014. 23
- Evidence of Daughter 23
  - Evidence from the Prince Charles Hospital 24
  - Evidence of GP, Dr SK 27
  - Evidence of Palliative Care Queensland. 31

Conclusions on the issues 34
Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act or referrals under s. 48. 38
Findings required by s. 45 42
  - Identity of the deceased 42
  - How she died 42
  - Place of death 42
  - Date of death 42
  - Cause of death 42

Comments and recommendations 43

Introduction

1. ES (Betty) was aged 87 when she died on 16 July 2014.

2. Betty had been very unwell for some time prior to her death, with significant medical conditions including ischaemic heart disease, chronic kidney disease and emphysema.

3. Betty was taking numerous medications for her heart, lung and kidney conditions and the blood thinning medication warfarin for atrial fibrillation.

4. On 29 June 2014, Betty was admitted to the Prince Charles Hospital (TPCH) with increasing shortness of breath. On 9 July 2014, Betty had a fall. A CT scan showed no head injuries. Her treating doctor spoke with her and her family and her family wanted to take her home. She was discharged on 10 July 2014 into the care of her family.

5. On discharge it was considered her main problems were congestive cardiac failure and atrial fibrillation. A chest x-ray showed an enlarged heart, collapse of the lung bases and fluid in the chest cavity.

6. After discharge the family requested a referral to the palliative care team. There was some information suggesting an in-home palliative care program was due to commence on 17 July 2014, although it is now apparent this was not the case.

7. Rather, Betty remained under the care of her daughter while at home with the assistance of Betty's GP, Dr KS. In addition to her usual medications, Betty was receiving oral liquid morphine, oxycodone tablets, fentanyl patches and fentanyl lozenges. Dr KS had not examined Betty since her discharge, and was due to see her on 17 July 2014. In the meantime, Dr KS had on the 15 July 2014 provided a written prescription for oral morphine due to concerns expressed by her family over the telephone.

8. On the morning of 16 July 2014, Betty died at home. Initially the GP issued a cause of death certificate indicating heart failure due to ischaemic heart

disease as the underlying cause of death. Her chronic kidney disease and emphysema were also included as contributing conditions.

9. On 17 July 2014, nursing staff at a private hospital (the Hospital) reported to their hierarchy that one of their enrolled nurses had made comments about assisting in the death of a family friend (Betty), possibly by administering medications. This information was reported by the Hospital to the police and the coroner and an investigation commenced.

The investigations

10. First response officers from the Queensland Police Service (QPS) and Queensland Ambulance Services (QAS) were called by Betty's family after she died, on the advice of the GP. The first to attend the address at Brighton was made by QAS officers followed shortly by QPS at approximately 11:30am on 16 July 2014. Contact was made by QAS with the GP who advised that she would issue a cause of death certificate outlining the cause of death as due to natural causes. On the evidence then available, the QPS properly determined that the death was not a reportable death under the *Coroners Act 2003*. QAS and QPS officers left the scene and the body was collected by a funeral director in preparation for a funeral in the normal manner.

11. Subsequent to the report of the conversation with the nurse at the Hospital, police were called by the Hospital and provided an immediate response. An initial investigation was commenced by Detectives from Brisbane City Branch on 17 July 2014.

12. The initial investigation revealed an enrolled nurse had allegedly made comments to her colleagues about assisting in the death of her family friend, and referring to herself as 'the angel of death' and 'Dr Kevorkian' (a known euthanasia advocate). When questioned by her employer about these comments, the nurse allegedly admitted giving her friend an excessive dose of morphine, and acknowledged that her actions could possibly be considered 'murder'. The nurse was immediately suspended from her employment and a report was made to police.

13. Further police inquiries revealed that the nurse was a close family friend of Betty and had attended at the home of Betty's family on the day of her death. It

was ascertained that Betty's body was being held at a particular funeral home and her body was located and transported to the Queensland Health Forensic and Scientific Services (QHFSS) government morgue on the order of the coroner. A warrant to search the premises of the nurse was issued.

14. Police then attended Betty's family's home on 18 July 2017, two days after Betty's death. Betty's family members voluntarily identified several items of medication still at the home, to police which were then seized. These included liquid morphine (Ordine), Endone (oxycodone) tablets, fentanyl patches and fentanyl lozenges.

15. Due to the address being within the North Brisbane CIB jurisdiction the police investigation was on or about 18 July 2014 then handed over to Senior Constable Timothy Heller from North Brisbane CIB. DSC Heller completed the investigation and prepared a report to the coroner.

16. The report to the coroner from DSC Heller indicated that police spoke to and obtained formal statements from a number of persons who worked with and allegedly heard the nurse's comments about assisting with Betty's death.

17. It became apparent legal advisors engaged by the Hospital in fact took a number of statements from staff members on the day of the incident and provided copies of those statements to DSC Heller in electronic form. These statements were then largely 'cut and pasted' into QPS statement form and then signed by the witnesses. The QPS statements and very similar statements prepared by the legal advisors were signed either on the same day or within days of each other.

18. Statements were obtained by the police investigators from QAS and QPS officers who had attended on the day as well as the GP who issued a number of medications to Betty after her discharge from hospital. Subsequent statements were obtained from funeral director staff who attended.

19. The Hospital hierarchy did not immediately contact police on the morning of 17 July after receiving the initial report of the conversation between nurses. The Director of Nursing and HR staff determined that they should first provide the enrolled nurse with an opportunity to provide an explanation as to her

comments on the basis there may have been an innocent explanation. Once the Hospital determined there was a concern, they sought advice from their legal advisors and were advised to contact the police. The police were contacted later the same day. I consider this was an appropriate response and course of action by the Hospital management.

20. At the same time, the Hospital legal advisors were requested to conduct an internal investigation to support any HR decisions that needed to be made, hence the gathering together of nursing staff who may have witnessed the conversations of the enrolled nurse and the taking of statements. The enrolled nurse was dismissed from her employment the following month. The Hospital properly reported the incident to the Office of the Health Ombudsman.

21. The seized medications were subject to drug analysis by QHFSS scientists and a Certificate of Analysis was prepared. Of significance, the contents of a 200ml Ordine 5mg bottle was quantified, which resulted in finding 182.930 grams of morphine being present and 175.9ml in liquid form remaining in the bottle. The purity results of the morphine was calculated to weigh 0.658 grams of morphine. This is equivalent to 3.8mg of morphine per ml of liquid.

22. An autopsy and other post-mortem investigations were performed. Toxicology testing showed potentially fatal levels in Betty's blood of two opioid analgesics, namely morphine and fentanyl. Oxycodone, another opioid analgesic, was also present but within a range that was considered to be non-toxic.

23. Police also attempted to obtain statements from the two family members who were with Betty when she died, as well as the nurse who allegedly made comments about assisting in Betty's death. All three of these individuals refused to provide formal statements, as was their right. It is understood they were acting in accordance with legal advice when refusing to give those statements.

24. DSC Heller determined that there was insufficient evidence to consider any criminal charges.

25. I express some concern that the important evidence of the alleged admissions against interest made by the enrolled nurse was not forensically gathered by

the police, but largely adopted statements taken by civil authorities for another purpose. This did not impact on my investigation but may have had an impact in other jurisdictions if charges had been commenced.

Decision to hold inquest and issues for inquest

26. In the absence of statements from those individuals with direct knowledge of the last days and hours of Betty's life, and in light of the concerns raised that Betty may have been given an excessive dose or doses of morphine, possibly deliberately, it was determined to hold an inquest to further investigate the circumstances of her death.

27. The inquest intended for there to be further investigation into the factual circumstances surrounding Betty's death. It was also intended to explore the broader issue of the adequacy of palliative care support services available to families who are caring for loved ones with terminal medical conditions.

28. At the pre-inquest hearing, I issued a non-publication order prohibiting the publication of any information identifying the deceased person, and all witnesses including QAS officers, who were to be called or who were referred to during the inquest. This was extended to including non-identification of the Hospital where the enrolled nurse was employed. The non-publication order excluded the investigating officer and other expert witnesses independent to the investigation. I made the non-publication order due to a concern that the controversial nature of some of the evidence had not been tested and may have unfairly damaged the reputations of some of those persons/organisations involved. This order remains in force until further order.

29. The following issues for the inquest were set:
    a) The findings required by section 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death.
    b) The circumstances leading up to the death, including whether medications were administered to the deceased to hasten her death.
    c) Whether the deceased and her family were provided appropriate end of life care support and services following her discharge from TPCH on 10 July 2014.

d) Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act

List of Witnesses Called

- Detective Senior Constable Timothy HELLER
- LM, Registered Nurse,
- TL, Registered Nurse,
- GC, Registered Nurse,
- SA, Clinical Nurse,
- LS-H, Clinical Nurse Manager,
- RC, Director of Nursing,
- BC, Human Resources
- Dr SK, General Practitioner,
- SS, funeral home employee
- RM, son-in-law
- GS, daughter
- MB, enrolled nurse
- Dr Treasure MCGUIRE, Consultant Pharmacist and Pharmacologist
- Dr James Stevenson, Clinical Director of the Palliative Care Service, as the most appropriate person from TPCH to provide evidence of end of life care planning and supports provided to the deceased and her family following her discharge from TPCH on 10 July 2014
- Dr William Syrmis, Palliative Care specialist on behalf of Palliative Care Queensland

What is palliative care?

30. The facts of this case indicated that the definition and practice of the provision of palliative care needed to be understood.

31. Palliative care is defined by the World Health Organisation as *an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*

Palliative care:

- *Provides relief from pain and other distressing symptoms*
- *Affirms life and regards dying as a normal process*
- *intends neither to hasten or postpone death*
- *Integrates the psychological and spiritual aspects of patient care*
- *Offers a support system to help patients live as actively as possible until death*
- *Offers a support system to help the family cope during the patient's illness and in their own bereavement*
- *Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated*
- *Will enhance quality of life, and may also positively influence the course of illness*
- *Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complication.*

32. Hence palliative care is not simply about providing comfort care and pain relief at the very end of life, although that is a very important part. It is not euthanasia, where the act has an intention of putting to death or allowing a person to die.

33. There is a considerable amount of accessible literature concerning what comprises good palliative care. There have been a number of parliamentary enquiries about palliative care and services available and it is evident there is a considerable amount of work taking place to support safe, good quality home based palliative care.1 This inquest did not consider the efficacy of palliative care services generally. This is no doubt a complex area of practice, no doubt subject to resource pressures and no doubt is generally conducted very well by

---

- [1] Federal Senate inquiry into Palliative Care in Australia, report dated Oct 2012
- Qld Parliamentary Committee Inquiry into Palliative & Community Care in Qld, report dated May 2013
- QH Statewide Strategy for end-of-life care, May 2015
- *Guidelines for Handling of Medication in Community-Based Palliative Care Services in Qld*, March 2015 (issued by QH)
- The QH Palliative Care Service (both inpatient and community based service, including 24hr advice line) – brochure
- QH Centre for Palliative Care Research and Education: https://www.health.qld.gov.au/cpcre/default.asp
- QH "Community Based Palliative Care Education Project" (providing education to GPs and paramedics): https://www.health.qld.gov.au/cpcre/cbpcep.asp
- Peak NGO bodies in Qld (http://palliativecareqld.org.au/) and Australia (http://palliativecare.org.au/)

dedicated medical and nursing professionals, either through specialist palliative services and/or through general practitioners and nurses providing support to patients and families in the community. The issue considered in this case was whether there were any identified gaps in services that were available that could have been provided to Betty and to the family. In that respect I received assistance through statements and oral evidence from the Palliative Care Service at TPCH and a review conducted by Dr William Syrmis, palliative care specialist on behalf of Palliative Care Queensland.

34. Dr Stevenson, the Clinical Director of the Palliative Care Service at TPCH stated there are many phrases surrounding the two words 'palliative care' but it was important to note the difference between, on the one hand, the role of a 'specialist palliative care service' and the more broad concept of adopting a 'palliative care approach' to an individual's needs. He stated the latter 'palliative care approach' is something any health professional should be able to do when caring for people with incurable, and potentially fatal, diseases. The former 'specialist palliative care' becomes relevant and of clinical importance when continued treatment of a patient's health issues becomes complex to a point other non-specialist health professionals feel additional assistance is required.

35. Dr Stevenson stated that if there is no specific need for routine specialist palliative care involvement, it is reasonable for a patient's palliative approach to be followed by the general practitioner, primary care providers and other community health teams. These entities understand that a fresh referral to a specialist palliative care team can be initiated at any point.

36. In respect to the legal status of palliative care it is legal for doctors to provide pain relief that hastens death as long as the intent was to alleviate a patient's suffering, was not provided with an intent to kill, and the treatment accorded with good medical practice.[2]

37. Palliative care is specifically provided for in legislation in Queensland. *The Criminal Code (Qld) section 282A* in summary provides that a doctor, <u>or someone authorised in writing by the doctor</u>, who hastens a patient's death

[2] See for example the website of the QUT based The *Australian Centre for Health Law Research* https://end-of-life.qut.edu.au/palliative-care

through palliative care, is not criminally responsible for the patient's death if the palliative care is:

- to maintain or improve the comfort of a person who is subject to pain and suffering; and
- provided in good faith and with reasonable care and skill, and is reasonable and in accordance with good medical practice.

Autopsy results

38. The autopsy examination was conducted by Dr Nathan Milne, forensic pathologist. An internal examination showed significant pre-existing natural disease. The heart was enlarged and there was severe narrowing of the coronary arteries. There was no evidence of an old or recent heart attack. There were fluid collections in the chest cavities. The lungs showed no obvious pneumonia. The kidneys were small and scarred and showed diabetes related changes. There were Alzheimer's type changes in the brain and hypertensive changes with amyloid deposition.

39. Toxicology found both free (0.53mg/kg) and total morphine (1.5mg/kg) levels within the range considered potentially fatal. The total level in the liver was also high. Morphine was also present in the stomach (50mg/kg indicating 8mg present).

40. Fentanyl was also found within the potentially fatal range (blood concentration 0.006mg/kg). Oxycodone (blood level 0.02mg/kg) was found in a therapeutic range and paracetamol was at a low level.

41. Blood samples were also obtained from TPCH on the day of Betty's recent admission being on 10 July 2014. Testing showed non-toxic levels of paracetamol, warfarin and metoprolol. No opioid drugs were present.

42. The forensic pathologist noted that the cause of death was best considered as 'undetermined'.

43. Dr Milne noted Betty was very unwell, primarily due to congestive cardiac failure, which was due to ischaemic cardiomyopathy, which was due to coronary atherosclerosis. The post-mortem examination showed severe heart disease and features of congestive cardiac failure. She also had other

significant medical conditions including atrial fibrillation, emphysema (due to smoking) and chronic kidney disease primarily due to diabetes. Dr Milne noted the information provided suggested the medical disease was of such severity that she had been referred to a palliative care service. Death in such circumstances is therefore not unexpected.

44. The pathologist noted however, that allegations of over administration of medication were raised. Toxicology testing showed potentially fatal levels of two opioid medications namely morphine and fentanyl. It is recognised that administration of opioid medications palliatively to achieve patient comfort can accelerate a patient's death. Therefore, under normal palliative care practice, someone may have high levels of opioid medications in the blood.

45. Metabolism of opioid medications can be affected by old age and renal failure. This could result in higher than expected blood levels of opioids. Another consideration in the interpretation of these drug levels is the degree of tolerance to these medications but it appears in this case she had only been receiving these medications for a short period of time. Therefore, the high drug levels would have had a greater effect than if she had developed a degree of tolerance.

46. Dr Milne considered the death was due to a combination of significant pre-existing natural disease and mixed drug toxicity. The cause of death was stated as ‘undetermined’ as there was uncertainty about the administration of the drugs.

47. Dr Milne recommended the opinion of an expert in opioid medication prescribing and interpretation be sought.

Expert report of Dr Treasure McGuire

48. An expert report was subsequently obtained from Dr Treasure McGuire, a consultant pharmacist and pharmacologist, who was asked to provide an opinion on the role medication may have played in Betty’s death.

49. Dr McGuire undertook a detailed review of the police report, medical records, and autopsy and toxicology findings. She also made enquiries with the manufacturer of the oral morphine medication found in Betty’s family’s home to

obtain a more accurate estimation of how much morphine was missing from the medication bottle. Dr McGuire was able to ascertain that the manufacturer allows for a overfill target of between 14ml to 18ml in order to ensure there will be at least 200 ml of Ordine in each unopened bottle during the product's shelf life.

50. On the basis that 24.1ml was certainly missing from 200ml bottle, Dr McGuire identified by taking into account an overfill of a minimum of 14ml, that at least 38ml of liquid was missing from the oral morphine bottle. This was equivalent to a dose of 190mg, which had only been dispensed to Betty over a period of approximately 24 hours prior to her death. Betty had been prescribed morphine 1-2 ml three times daily when necessary (i.e. a maximum of 6ml or 30mg daily). Dr McGuire stated this was consistent with a low to moderate dose range. If 38ml of oral morphine was administered to Betty in that 24 hour period, she would have received an amount of morphine that was more than six times the intended daily dose.

51. Dr McGuire stated that the levels of morphine found in Betty's blood and liver were consistent with this level of excessive dosing.

52. Dr McGuire also noted the presence of 8mg of morphine in Betty's stomach, which suggests a dose above the prescribed dose was given to Betty shortly before her death.

53. Dr McGuire concluded that excessive morphine doses were a major contributing factor to Betty's death.

54. She noted the presence of additional opioids (fentanyl and oxycodone) in Betty's blood, and advised these medications would have added to the respiratory depressant effects when combined with Betty's morphine levels. Betty's fentanyl levels in particular were within a range Dr McGuire described as 'supra-therapeutic', that is, greater than the amount required to treat a medical condition, and likely to have been toxic.

55. Dr McGuire identified concerns regarding both the prescribing practices of the GP who was managing Betty's pain in the days prior to her death, and the possible over-administration of fentanyl patches and lozenges by Betty's family

during this period. It should be noted that although Dr McGuire noted no documented GP instructions in the medical notes or prescription labels on how fentanyl was to be administered (dose form, dose and/or frequency), the investigation has now revealed this is largely due to the fact the GP had not prescribed the fentanyl for use whilst Betty was in the care of her family. The GP was unaware the family had been supplied with five fentanyl patches from *unused* and *ceased* medication held at the nursing home.

56. Dr McGuire noted the GP organised a supply of 20 Actiq 200mcg fentanyl lozenges, taken from the medical practice's controlled drug cupboard, with no prescription apparently recorded, in response to a call from Betty's daughter on 14 July 2014. There was some contention as to the number of lozenges that were found at the residence, possibly suggesting up to seventeen lozenges were used over a 48 hour period but I accept that given other evidence now available most of the lozenges were returned to the GP by the son-in-law. In any event, Dr McGuire considered that even if all unaccounted lozenges had been administered, this dose in isolation, would have been unlikely to produce the toxicology level found at autopsy.

57. Dr McGuire considered there was a role for the administration of residual Fenpatch transdermal patches to explain the supratherapeutic fentanyl blood levels observed. Dr McGuire stated nine to 11 patches were initially unaccounted for, but I accept later evidence suggests five patches were provided to the family from the nursing home medications with one unused patch found at the scene and two on the body. This would suggest four patches had been applied over the six day period (the box prescribed one every three days meaning double the recommended dose). There was the added difficulty that the product information requires an expired patch to be removed as there is still fentanyl being introduced into the system from the older patch.

58. Whatever the case was with respect to the confusion regarding unaccounted for medication, the toxicology levels found at autopsy speak for themselves and are consistent with Dr McGuire's overall evidence.

59. As to cause of death, Dr McGuire formed the opinion Betty's death resulted from a combination of significant pre-existing natural disease and mixed opioid

drug toxicity, however drug toxicity constituted the major change in the last 24 to 48 hours of Betty's life. I accept that opinion.

The circumstances leading up to the death, including whether medications were administered to the deceased to hasten her death.

60. Prior to the inquest, I gave each of the persons who were present when Betty died on 16 July, a further opportunity to provide a statement. An unsworn statement was provided by MB, and sworn statements were provided by Betty's daughter and Betty's son-in-law.

61. They were each summoned to provide oral evidence at the inquest. Each of them declined to provide further evidence on the basis it may incriminate them. I directed each of them to provide evidence under section 39 of the *Coroners Act 2003* on the basis it was in the public interest for their evidence to be heard but that any evidence given, including derivative evidence, could not be used against them in any criminal prosecution, except in relation to a charge of perjury in the event they were found to give false evidence at the inquest.

62. It was apparent the timeline of events described by MB in her statement was inconsistent with that of Betty's daughter and son-in-law. MB stated she compiled her statement whilst on a holiday overseas and without access to any records. The timeline provided by Betty's daughter was also consistent with telephone records she produced. MB conceded the timing of events was more accurately described by these records and I have found no need to specifically deal with any inconsistency on that topic.

Evidence of daughter

63. The daughter stated that the administration of her mother's medication was primarily performed by her. She was her mother's Enduring Power of Attorney and attorney under an Advanced Health Directive. She states her mother was not in a position to be able to make any decisions regarding medication by the time of her discharge. She stated she did not have any discussions with her mother about decisions to administer the medication. She stated her mother would often spit out medication and adopted a few strategies to alleviate this.

64. Later she started using morphine lollipops (in fact they were fentanyl) but her mother was often agitated and she would throw them on the floor.

65. She stated that even when she used a syringe to administer oral medication her mother would spit some of it out.

66. The daughter stated she had discussions with a doctor from the hospital and a nurse on 11 July 2014 asking about what medication she should prioritise and was told to concentrate on bowel and pain medications. She tried to contact a local GP practice to accept her mother as a patient but they would not attend on home visits. It should be noted her mother's regular GP saw her at the nursing home near to where her practice was and this was now some 25kms away from the daughter's residence.

67. On 14 July 2014, the daughter spoke to her mother's GP, Dr SK. She says she told the GP her mother appeared to be in pain and was consistently not taking any medication for pain relief. The daughter believed her mother had injured her shoulder again as a result of the fall. The GP suggested the use of pain relief lollipops and these were collected by her husband. During the conversation she discussed with the GP about treating her mother as palliative in an attempt to keep her comfortable. She stated it was agreed with the GP they would attempt to keep her pain-free and comfortable. She says she was aware the GP had organised for a home visit on 17 July 2014 to consider palliative options.

68. The daughter told the inquest that her mother may have had only one to three lozenges as a maximum, but they were not working. It was put to her that 20 lozenges were dispensed and 12 were returned to the GP with three found at the scene. The daughter accepted she could have given her mother up to five lozenges over that 24-hour or so period.

69. In respect to the fentanyl patches, the daughter stated in her evidence she picked these up from the nursing home in a bag of medication. She thought they were for her heart and recalls the instructions on the box were to apply one patch to the skin every three days. She told the inquest she was not aware the GP had ceased these medications prior to her mother going into hospital and did not discuss this medication with the GP subsequently.

70. On 15 July 2014, the daughter again telephoned the GP as her mother was extremely agitated. She asked the GP if there was another form of morphine that her mother could take. Her husband collected the oral morphine later on the morning of 15 July. She states she administered the first dose of morphine at approximately 12pm on 15 July 2014. This is consistent with the timing of the collection of the prescription from the chemist by her husband as confirmed by CCTV within the chemist premises.

71. The daughter says she understood the dose to be a fairly small dose of 1-2ml, three times a day, or as required. In her evidence she stated this dosage order means to her that it can be given more than three times a day. She later stated she was not sure why, but she had it in her mind the dose should not be given any more frequently than four hours. She stated that when she administered the liquid morphine her mother would swallow some of the medicine on occasions, but on other occasions, she would dribble some of it out.

72. She believes she continued to provide her mother morphine at approximately four hourly intervals. In her evidence she stated she would have only given her half a dozen doses over that almost 24 hour period.

73. At the inquest she was asked about any discussions she had with the GP concerning medication instructions but could not recall any verbal conversation. She stated she followed the instructions given on the box or the bottle.

74. On 16 July 2014, the daughter says her mother's breathing had become laboured, sounding similar to a rattling sound. She said the sound was extremely distressing and frightening. Her mother started to cough at this time and it sounded similar to someone choking. She stated she had given her mother a dose of morphine at approximately 8:00am.

75. At some time approaching 9:30am she sat her mother up and some green fluid came out of her mouth. She called her friend MB, an enrolled nurse, and requested her assistance

76. Telephone records indicate she rang her friend the nurse at 9:21am. She stated that at some time after 9:30am, her friend MB, the nurse arrived and her

mother was quite agitated. She told MB she had administered morphine at approximately 8:00am but advised she was unsure how much her mother had taken in. At this point they discussed giving Betty an additional dose of morphine and she says the nurse drew this up using the same syringe she had been using and gave it to her mother. The daughter says some of this drooled out.

77. At this point the daughter stated she personally was extremely distressed and crying and felt that her mother was suffering and left the room to compose herself. When she returned approximately fifteen minutes later her mother appeared to be calmer and more comfortable. The daughter decided to take a shower. Her husband had arrived. When she returned her mother had passed away. She was not present in the room at the time.

78. The daughter was asked whether anything she saw that morning was suggestive of an excess of dose or anything more serious such as 'murder'. She stated that not from what she saw and her friend MB was very caring to her mother.

Evidence of son-in-law

79. The son-in-law stated his wife and he had regular discussions with Betty's treating doctors about bringing her home from hospital and decided it would be best to bring her to their house as she was now going to be classified as a high-care resident. He purchased a number of items to facilitate her transition into the home including two single beds and railings. They also hired an air mattress and other medical items.

80. He stated that the administration of medication was done solely by his wife and he had no discussions with her about the medications.

81. He stated he had all of the discharge summary scripts filled at a local pharmacy and collected a prescription for morphine lollipops from the GP on one occasion and a prescription for oral morphine on another occasion. He had no recollection of discussions with the GP about the medications and the dosing was written on the prescription.

82. To the best of his knowledge his wife was administering medications to Betty as prescribed.

83. On the morning of Betty's death he was at work. His wife telephoned him in a panic at 8:30am and said that Betty was breathing abnormally. He received a later call saying that a friend of Betty's who was a nurse was on her way and he did not need to hurry.

84. He arrived at home at 10:00am. He told the inquest he did not discuss with his wife what medications had already been given to Betty that morning. He was not present when any medications were provided by either his wife or the nurse. He later found out that the nurse had given some medications but he cannot recall if it was before or after he arrived. He stated his wife told him later she had given Betty a dose at 8:00am and some dribbled out and she was not sure how much had gone in. There was then a suggestion of another dose being given and he believes the nurse also gave a dose but he was not sure how much.

Evidence of MB, enrolled nurse

85. MB provided an unsworn statement prior to the inquest and gave evidence at the inquest. The most significant issue that needed to be clarified was how many doses of oral morphine were provided to Betty on the morning of 16 July 2014.

86. Her statement stated she was only involved in administering one dose of oral morphine that morning. She stated she carefully syringed the medication slowly into Betty's mouth taking care that Betty was attempting to swallow all of it. In her statement she stated she was present when three doses of oral morphine were given. She directly administered one of the three doses. She stated she was involved in a discussion regarding the need for oral morphine with the daughter for two doses and subsequently with the son-in-law for the third dose. This evidence was qualified in her oral evidence before the inquest. She also stated her statement was provided whilst she was overseas and without recourse to any records and was drafted from her memory of those events some two years later.

87. In her evidence before the inquest she stated she was aware that Betty's daughter had given her a morphine dose prior to her arrival. When she arrived they determined they would give her a further dose of oral morphine and this was provided by the daughter. She was not sure of the amount of the dose or whether all of it went through.

88. Later in the morning she gave a third dose. Betty's daughter had gone outside for a moment and she was alone with Betty. She told the inquest she gave her a *good dose to prevent her suffering*. Initially she acknowledged that the dose provided by her was 4ml. She said at this stage the son-in-law came home and they discussed giving her another dose but before that happened they decided to clean her up after there was a smell emanating from her body and during the course of this they realised Betty had died.

89. She stated she did not discuss the amount of the dose she provided to Betty with the daughter. She accepts on reflection that she was not particularly careful about how much had been given.

90. Upon further questioning during the inquest, she acknowledged the amount she drew up also could have been 5ml or even possibly the whole of the syringe. She stated she was providing medication on a when necessary basis (PRN). She stated she gave this dose slowly inserting the syringe to the back of the mouth to assist her swallowing.

91. She also acknowledged that as an enrolled nurse she is not qualified to administer this type of medication except with supervision, but on this occasion she was acting in her private capacity and not as a nurse.

92. She was also aware Betty was receiving OxyContin and was aware this was an opioid. She also observed a fentanyl patch on Betty on 16 July 2014 and believed she saw it on her back when rolling her over after the dose she gave. She gave evidence that prior to seeing the fentanyl patch she was not aware Betty was receiving fentanyl.

93. She told the inquest her intention in providing the dose of oral morphine was to try to make her breathing less laboured. She was aware morphine depresses the breathing and respiratory drive and understands this makes respiratory

drive less strong. She stated she considered this would slow her respiratory drive and ease the heavy breathing.

The evidence of events subsequent to death

94. There are two aspects to the events subsequent to death which I can deal with briefly. Firstly, the evidence of those who attended shortly after the death and secondly, the admissions made to nursing staff by MB.

First Response Officers

95. I received statements from first response police officers and QAS staff who attended at the residence in response to a telephone call from the son-in-law. It is unnecessary to detail their evidence, which is consistent with nothing being identified as suspicious. It is apparent the son-in-law identified himself as an ex-paramedic. In a conversation with a QAS officer he stated the patient had been brought home for palliative care and commented they did not wish her to die alone in hospital. The male person appeared to be calm and offered information. He did question why they needed to attend and stated he had called the GP who was willing to write a cause of death certificate but he had been asked to call them also.

96. The son-in-law also described Betty had agonal respirations during the morning and soon after that had lost her pulses, was not breathing and without heartbeat. It was explained that she was under a Not for Resuscitation order and her end of life wishes were to just be made comfortable. The QAS officer observed that the lady identified as the daughter was emotionally distressed with tears in her eyes. They then confirmed life extinct. She then spoke to the GP who told her the patient was palliative with terminal renal failure and heart failure and was satisfied and happy to issue a cause of death certificate. The QAS officer then provided this information to the police who had arrived shortly after. It was apparent to all concerned that on the basis a Cause of Death certificate was being completed QAS and police were no longer required.

97. Similarly the evidence of the funeral director employees who attended expressed no concerns identifying unusual behaviour on the part of those present, which would have led to a consideration of there being suspicious circumstances.

Admissions made by MB to nursing staff

98. The inquest received statements from various nursing staff who over-heard conversations in the tea room of the Hospital on the morning of 17 July 2014. I do not intend to detail those conversations in other than a general manner. The tea room is apparently a busy and noisy room at times. Some nurses took part in the conversations with the enrolled nurse MB. Some heard just portions of a conversation. Some were some distance apart and heard little of any conversations. This is all consistent with expected normal interpersonal interactions in such an environment. Of significance is that MB does not deny the general tenor of the conversations that were repeated and did not challenge the witnesses otherwise.

99. It is apparent the conversation started with one nurse describing how she was upset at having to put down a beloved pet. MB is then heard to say to a number of persons, words to the effect of 'there needs to be an open discussion about this', 'I was not going to let her suffer' and 'I want to start a conversation about this', 'I believe in the use of euthanasia and we should do more of that around here'*.* At least two nurses heard MB refer to herself as 'the angel of death' and 'Dr Kevorkian'*.* One nurse described that MB had stated her friend had died yesterday and she had 'given a good helping hand or significant help to die'. MB reportedly told one nurse she was proud of what she had done and there needed to be an open discussion about these things.

100. The subject matter of this conversation was reported to the Hospital Clinical Nurse Manager (CNM). The CNM was given information that MB was overheard telling people she had given a good dose of something to an elderly woman who was the mother of a friend of hers and the lady had died. She spoke to MB and said words to the effect 'I am hearing stories from the team that you have been talking about assisting in a woman's death'. MB replied in a matter of fact way 'yes that's right'*.* MB indicated she was aware this may have been illegal and explained the lady had multiple comorbidities and she was not going to let her suffer. She was insistent she had done the right thing by her friend's mother. She stated, 'I do not care if they send me to prison, I want to start a conversation about this'. She said people should not have to suffer. The CNM asked MB whether she had just given the lady the dose the doctor had prescribed, but MB said she had not, she had definitely given more. At some point during this next discussion MB told her she had given the woman

morphine. MB then became very emotional. The CNM then reported this verbally to more senior nursing staff and then reported it by way of an email to the Director of Nursing (DON).

101. MB was then requested to attend a meeting. This was held in the presence of the DON, a HR representative and a support person for MB.

102. The DON stated that MB said the tea room conversation was just a private conversation within a group of colleagues. MB initially would not tell any details other than her friend's mother was sick, old and very unwell. MB was directly asked by the DON whether she had assisted in her friend's mother death and MB said her friend's mother had told her 'I would like to be peacefully out of this world' and she respected her wishes. MB also acknowledged that she understood that what she had done could be considered 'murder'. She was asked whether the medication she had given her was an excessive dose and MB said words to the effect 'yes' and said it was morphine. She was asked where the medication had been obtained from, to which MB replied 'through her doctor'. She confirmed she had given her more than the ordered dose explaining the lady was like family to her and she could not let her suffer.

103. MB was described to be extremely upset at this stage but explained they had given the lady some morphine and then rolled her over to give her a wash and by the time they rolled her back they realised she was dead. She was asked at the meeting whether she had simply administered the prescribed dose of morphine, and MB stated it was 'not a normal dose' or words to that effect. MB did not deny that she had assisted by providing an excessive dose of morphine and acknowledged she had been talking about it in the tea room earlier that day amongst friends and colleagues. She was insistent throughout she had done the right thing.

104. During the course of the meeting she did acknowledge that what she did could be considered murder. She kept saying that as a nursing profession we need to have a conversation about this, explaining that it is out there and we need to talk about it more. The DON was surprised with these responses and she thought MB would have just told her they were assisting her friend to administer a dose of morphine as prescribed by a doctor. However, the DON said the

responses from MB made it clear she had given more than the prescribed dose.

105. MB told the inquest the conversations she had in the tea room were misconstrued and the reference to ‘angel of death’ was a joke. She admitted she spoke about attending her friend’s house to care for her mother and had given her a ‘good dose of morphin’. She agreed she made comments about having to talk about this and that some people were suffering too much. She agreed she stated we need to have a conversation about this.

106. She told the inquest the conversations she had in the tea room were misconstrued and the reference to ‘angel of death’ was a joke. She admitted she spoke about attending her friend’s house to care for her mother and had given her a ‘good dose of morphine’. She agreed she made comments about having to talk about this and that some people were suffering too much. She agreed she stated we need to have a conversation about this.

107. She agreed that during the meeting with the DON she told them she had given more than the prescribed dose. She agreed she probably said ‘I do not care if they send me to prison’ but she was probably being dramatic. She agreed she ‘probably or possibly’ said words to the effect ‘it could be considered murder’

108. She also stated she was angry at the time that something that had nothing to do with her work at the Hospital had come to their attention.

109. She stated she accepted she was partly responsible for the findings concerning the extent of morphine in Betty’s system. She stated her intention was to treat her breathing but knows that this can hasten death if it was to relieve symptoms at the end of life.

110. She stated she did not give the dose of morphine to hasten the end of Betty’s life and was surprised she had died. She thought they had more time.

Whether the deceased and her family were provided appropriate end of life care support and services following her discharge from the Prince Charles Hospital on 10 July 2014.

Evidence of Daughter

111. Betty's daughter noted in her statement that her mother had been residing in a low care facility for a number of years. She went to TPCH after suffering a heart attack. She stated that in the week or so up to her discharge, she felt her mother was deteriorating. She was unable to feed herself. She stated she entered into discussions with the hospital about her mother coming home to stay with her. The plan was for her to come home around 10 or 11 July but first the doctors wanted to give her some medications for her kidney. On the morning of 10 July 2014, she found out her mother had a fall overnight. She considered her mother had deteriorated since the day before and was confused and staring blankly. She thought that it would now be the better time to bring her mother home. She describes that she had a good discharge planning meeting with the social worker, occupational therapist, discharge planner and the treating doctor.

112. Prior to leaving the hospital she organised for the family to obtain various goods to help her mother reside in the house. They purchased two single beds that were installed in the master bedroom as well as a pressure-area mattress, shower chair, wheelchair, and bed rails. The plan was that the family would take turns in ensuring somebody was always with Betty and she would not be left unattended. The decision was made within the family for the daughter to manage Betty's medication to avoid the potential for error.

113. Betty's daughter also stated that they had received an ACAT assessment in hospital showing she needed high care. They looked into trying to get some transition care with the hospital but nothing was available. There was no known transitional funding available. She stated she made enquiries with a number of community care providers to see what services were available, but there were none.

114. In her statement Betty's daughter stated the hospital doctor agreed to her mother being discharged and the doctor said that a nurse would come and visit her mother the next day on 11 July 2014. She states that a nurse telephoned

her to advise that the paperwork had been sent to the wrong district. The nurse apologised and said she would not be able to come and see her mother until the next week.

115. It is apparent the referral to Post-Acute Care Services did go to the wrong office. It is also clear the correct area received the referral the same day and a clinical nurse with Post-Acute Care Services telephoned on 11 July 2014. She stated she had a long conversation with Betty's daughter. The daughter does not recall this telephone call but accepts it could have happened.

116. The services referred to in the referral notice included nursing assessments, daily living functional assessments, home safety and pressure injury prevention assessment, personal care assistance and social work for carers' stress and sustainability of care and arrangements. During the conversation the nurse stated they discussed a number of issues. The PACS nurse stated it was evident the family had hired or bought a pressure reduction mattress, cushions, chair and bed rails. They discussed oral intake, prophylactic aperients and analgesia. They also talked about the services requested from the Post-Acute Care Service and that the daughter felt at this point in time the family wished to care for their mother themselves and did not require any support from post-acute care. The plan was to phone on 15 July 2014 to see how the daughter and family were coping.

117. The daughter also does not recall this second call, which is noted in the hospital progress notes. I accept it was made. On 15 July, the nurse records in the notes that she telephoned the daughter and was told that 'Karuna' (a palliative care service) and the GP were caring for the mother and post-acute care services were not required. The case was closed to the service. The daughter claims no knowledge of reference to 'Karuna'. Given the contemporaneous recording of the notes, I accept some reference to that service must have been made and with the passing of time the daughter has forgotten.

Evidence from the Prince Charles Hospital

118. Dr James Stevenson is the Clinical Director of the Palliative Care Service at TPCH. He had no personal dealings with Betty but provided a statement after reviewing the medical records. Dr Stevenson noted Betty had been referred to

the TPCH Palliative Care Service in 2009 and he also reviewed the services provided over the period, 2009 to 2011, which was not a focus of this inquest.

119. In relation to the events of 2014, Dr Stevenson noted that Betty's health steadily improved from the acute problems after admission but there were always concerns about her long-term survival and ideal location of care. The options were to upgrade her to a higher level of care but in this case the family consistently wished to have her discharged home to their care due to concerns her survival was not going to be long and that she would prefer not to be living in an institution at the very end of her life. Dr Stevenson stated there were multiple discussions between the various health professional streams about the ongoing treatment options. Dr Stevenson stated that until the day prior to discharge, it was not obvious from reading the medical notes that the family had any concerns about the proposed plan of a community care package. In this case the family developed a wish for an early discharge and before any of the granted care packages could begin.

120. Prior to the family wishing for Betty to be discharged quickly, there were multiple discussions about referrals to community-based transition care programs. These packages are designed to provide an appropriate amount of in-home care whilst waiting for a more permanent high level care package.

121. Dr Stevenson stated that whilst it would not have been surprising if Betty was to experience another acute deterioration and even die from one of her various illnesses within the next 6–12 months, there were no immediate signs she was going to die within days or weeks of leaving hospital.

122. Betty's daughter agreed there were no signs that Betty would die soon. She had bounced back in the past and they had not had a conversation about her dying soon. The daughter was asked about palliative care and she recalls having a discussion with one of the doctors and asked if they would refer her to a palliative care service. She understood that if she was referred, a nurse would come and assist her in relation to healthcare management including pressure sores, nutrition, and medication. She agreed she had not received any advice about a service to contact as she did not think they were at that point.

123. Dr Stevenson stated the goals of care and discharge shown throughout the medical records indicated the treatment plans were focused on restoring health, maximising safe mobility and independence and providing the family with sufficient community-based supports whilst ensuring her medications were being prescribed in the safest possible way.

124. Dr Stevenson noted there was a single entry from a renal medical officer who documented on 3 July 2014 that he had spoken with the daughter who had asked about palliative care and said she was thinking about palliative care down the line. There was no immediate discussion other than to suggest she should be talking to the principal medical team about this. Dr Stevenson stated there were no other notes he could see during that admission raising the topic of palliative care.

125. The medical records also noted advice was given to the daughter about re-presenting to either the GP or the emergency department in the event of a recurrence of heart failure or palpitations. Betty's daughter stated in evidence that the point was for her mother to be cared for at home, but if she had to go back to hospital she would have rung the ambulance.

126. Dr Stevenson noted the staff working in discharge planning then tried to make urgent referrals to alternative home focused care, such as the Post-Acute Care Service or Hospital in the Home. Transition care packages required Betty to remain an inpatient beyond the intended date of discharge whilst waiting approval and the alternative of utilising the Post-Acute Care Service appeared to be acceptable to the family. Dr Stevenson stated that at no point during the admission was any suggestion made by the health professionals that Betty needed to be referred to palliative care at all, let alone a home-based 'Care of the Patient' concept.

127. Dr Stevenson stated if that had been the case, the consultant providing direct care to the patient was someone who makes frequent use of their service and was also capable of providing a good basic palliative care approach. He stated the palliative care team will frequently have conversations with the ward nursing staff about potential future patients.

128. In summary, Dr Stevenson stated that at the time of discharge it was acknowledged that Betty was living with a serious overall medical situation, which included a number of conditions that could prove fatal at some point in the following months. However, the goals of care at that point were focused on restorative care, not palliative care. The notes do not indicate care of an imminently dying patient was needed. Had a referral to the palliative care service been made by the treating team, it would not have been rejected by this service. The medical records noted there had been reasonable improvement during the admission for the acute onset of conditions. Dr Stevenson stated that if palliative care input had been provided at this point, it would likely have been minimal, such as encouraging everyone to pursue the recommended discharge plans and to see the patient at a clinic a few weeks later.

129. Dr Stevenson noted there appeared to have been a request generated to the palliative care service following a request from the family, a day after discharge. This was a generic referral form, which does not read as though the referral is referring to an imminently dying patient. The referral was written with a date of 11 July 2014, a Friday. The document was received by the palliative care service on Monday 14 July. On the same day the palliative care referral was sent, another referral was sent simultaneously to the Post-Acute Care Service but it was not known to the treating team a referral had been made to palliative care.

130. Dr Stevenson stated what followed after discharge was a rapid deterioration, which was not expected. The medical file does not indicate anyone from the family or other health professionals recognised and responded to an acute deterioration in terms of trying to identify a cause and consider potential treatment options. He stated it should not simply be assumed this deterioration represented a dying patient. It is possible she had developed an irreversible problem, but without a thorough and impeccable assessment, it is not possible to simply assume that was the only possibility.

Evidence of GP, Dr SK

131. Dr SK provided a number of statements and gave evidence at the inquest. It is evident she undertook weekly visits to the nursing home where Betty was living prior to her admission to TPCH on the last occasion and attended to Betty regularly when requested.

132. Dr SK stated that in the weeks leading up to her death, Betty became increasingly immobile due to pain, shortness of breath and frailty. A decision had been made to commence the assessment process to obtain approval and funding for higher level care. Over the five year period she had treated Betty, her health had gradually declined and was adversely affected by complications associated with her Chronic Obstructive Pulmonary Disease, stage V kidney disease, pain in her shoulder and congestive cardiac failure. It is evident from the records, Dr SK saw Betty regularly and was responsive to her complex needs.

133. Her shoulder pain was diagnosed as subacromial bursitis and was treated with cortisone injection, Endone (Oxycodone) 5mg (half to one tablet twice daily) and the use of Duragesic (fentanyl) 25mcg patches.

134. Dr SK became aware of Betty's hospital admission probably after being informed of this by the nursing home. Dr SK was contacted by the daughter on 14 July 2014. The TPCH Discharge Summary was received by her after Betty had died. On 14 July 2014, she was informed Betty was at home but was not eating and was agitated. Dr SK stated she would attend on a home visit on 17 July 2014. She provided 20 Actiq lozenges from the practice's dependent drug cupboard, which was collected by the family.

135. On the morning of 15 July 2014, the daughter called to say Betty was not taking the lozenges. On the basis that Betty could not eat, Dr SK says she issued a prescription for liquid morphine oral solution 5mg, 1-2mg three times a day as required.

136. Dr SK was contacted by the family on 16 July 2014 advising that Betty had passed away at home. She advised the family to contact the police on the basis she had died at home. She agreed to complete a Cause of Death certificate after being contacted by ambulance officers. This was in light of her knowledge of the decline in her health over preceding months, principally as a result of her comorbidities.

137. During the five years that she treated Betty she considered the family to be very caring.

138. Dr SK also provided evidence concerning the process for prescribing medication to patients at the nursing home. The nursing home used one pharmacy. Each time she prescribed a new medication for a patient, this was recorded on a MPS Summary sheet including the dose and frequency it is to be taken. Each time a new prescription was made an amended MPS sheet is faxed to the pharmacy. Once the medication has been prescribed it was the usual practice to continue to dispense that medication to the nursing home until it was ceased or changed. All medication was provided directly to the nursing home and not to individual patients. Medication was provided to patients, one dose at a time by nursing home nurses and no medication was left with patients, other than in the case of medication being required to be taken at night when nurses were not available as it was a low care facility. Each time a medication was provided by a nurse, a nursing entry is made. If the medication is a scheduled 8 controlled drug (such as morphine or fentanyl), an entry was also required to be made in the controlled drugs register for the patient.

139. On 29 May 2014, Dr SK increased the dose of the Durogesic fentanyl patch from one every four days to one every three days. This was recorded on the relevant MPS Summary sheet. Dr SK was concerned about the increased use of Durogesic patches and had informed Betty on a number of occasions she would need to come off these patches.

140. On 27 June 2014, another doctor at the practice saw Betty. It was recorded she was becoming agitated, which was thought to be secondary to fentanyl use. As a result, the Doctor wrote the word ‘ceased’ next to the entry for the fentanyl patches.

141. Dr SK was not aware that in early July 2014 the nursing home returned all of Betty’s belongings to her family on the basis she would not be returning following her discharge from the hospital. This included all unused medications. Dr SK has consulted the nursing home records and notes there is an entry in the controlled drugs register on 3 July 2014 stating that 19 Endone and five

fentanyl patches were returned to the family. Dr SK stated she was completely unaware this medication had been given to the family and as far as she was concerned it had been ceased whilst she was at the nursing home.

142. It was Dr SK's usual practice to ask a patient what medication they are taking prior to prescribing medication for them but she does not recall whether she asked this question of Betty's daughter at the time. She certainly did not advise any member of the family to utilise the remaining Endone and Durogesic patches.

143. Dr SK has taken up this issue with the Clinical Nurse Coordinator at the nursing home. Dr SK informed the CNC that providing family with S8 controlled drugs was not a good practice. It was agreed a policy should be put in place at the nursing home to avoid a similar situation occurring and these were drafted and updated as a matter of priority. Those policies have been provided to the Court. This includes an amendment requiring the registered nurse to complete a 'Return to Pharmacy' form as soon as possible after a doctor has ceased a patient's S8 medication and this medication was to be returned to the pharmacy as soon as possible. Further control measures regarding the use of S8 medication including when residents are on leave overnight or on consecutive days as well as other amendments to policies, have been made.

144. Dr SK told the inquest she has no specific recollection of discussing with the family the use of the medication provided, although her usual practice is to say something about how it should be given. The intention in prescribing the oral morphine was it should be given if Betty looked like she was in significant pain but not more than three times a day. Her usual practice is to tell patients to adhere to the prescribed amount.

145. Dr SK says she did not have any discussions with the family specifically about the provision of palliative care but it was her assumption that because Betty had been discharged to her daughter's home, she was requiring palliative care. This was because at some stage in the past she had discussions with her daughter who stated she would bring her mother home if nothing more could be done for her. It was for this reason she was intending to visit the home on 17 July 2014 to assess her palliative needs. Dr SK's understanding of palliative

care was this was a stage at end of life when no further curative options were available.

146. Dr SK stated that in retrospect, although she was trying to be as practically helpful to the family as she could be at the time, it may have been more prudent for her to advise the family to contact an after-hours doctor, who could assess Betty. After hours doctors are available after 6pm but she could not be sure if the service her medical practice subscribed to would have conducted a home visit in the area where Betty was now living. She stated it would have been very unlikely a general practitioner who had not known Betty would have made a house call. Calling an after-hours doctor or a local general practitioner may have had practical difficulties as well, as that doctor would have no previous knowledge of her complex medical history.

Evidence of Palliative Care Queensland.

147. Dr Willam Syrmis is a palliative care specialist at a private hospital and has experience in managing palliative care patients in the community from both a specialist and a GP perspective. He provided a review and report in his capacity as a representative of Palliative Care Queensland, the peak representative body for palliative care practitioners and the palliative care community in Queensland.

148. Dr Syrmis reviewed the medical records and also read the statement provided by Dr James Stevenson.

149. It has to be said Dr Syrmis' report was based on an assumption Betty had been referred to community palliative care services and at the time of her discharge it had been recognised that Betty required palliative care. That was, in my view, a fair assumption to make, based on what had been recorded in the medical records and in particular a reference in a statement of Dr Pandy from TPCH who stated there were no formal palliative care plans formulated but a referral was made for the palliative care team to follow up in the community.

150. After considering the statement of Dr Stevenson, it is accepted by me that the discharge process was hurried because the family were keen to bring Betty home. It is also accepted, that although Betty had a number of serious co-morbidities at the time of discharge, which could have led to her death in the

next few months, she was not in a state at the point of discharge where she required urgent palliative care.

151. Hence, to the extent that Dr Syrmis is critical in his report of any time delay in the provision of community palliative care services on the part of Metro North Hospital and Health Services, he now accepts that with the extra information available, those concerns can be allayed.

152. However, Dr Syrmis did say that ideally the involvement of a community palliative care service would have provided 24-hour support and advice to maintain comfort and provided clear guidelines for the family on medication administration. Dr Syrmis stated that ideally this reference would be made during an inpatient stay. Ideally the family would be educated on symptoms to expect as heart and kidney failure worsened and to recognise symptoms that may suggest Betty was nearing the end of her life (e.g. refusal to eat, refusing medications, inability to mobilise, drowsiness for long periods, worsening delirium, etc.). The family would have also been educated on the process of dying, particularly to warn the daughter about the 'rattly breathing' that may occur, to prevent at least some of the distress the daughter had by the fright of such an unexpected and unexplained sign.

153. Dr Syrmis stated it is apparent the day after discharge Betty was reported to be deteriorating with increasing pain, agitation, confusion and refusal to take her medications and most diet and fluids. This would have included refusal to take the diuretic medication being used to prevent build-up of fluid on her lungs, so Betty was at risk of further deterioration with her breathing at that time. Dr Syrmis stated the information provided by the daughter on 11 July to the PACT nurse described signs of a patient nearing the end of the life and should have triggered an urgent review. Similarly the condition of Betty on 14 July indicated the need for such a review. It is of course evident Betty's daughter was declining any assistance so that is not a criticism of the PACT nurse or Metro North.

154. Dr Syrmis stated common symptoms for a patient dying of heart failure and kidney failure in those last few days may include shortness of breath, pain, nausea and agitated confusion. In the last hours or days of life, patients may develop rattly breathing either from fluid build-up in the lungs or from pooling of

secretions in the upper airway. When a patient is no longer able to swallow oral medications and the aim is for end of life care to take place at home rather than hospital then a community palliative care service comes out to the house to organise medications to manage the symptoms appropriately.

155. Dr Syrmis noted that ideally a palliative care team would have placed a subcutaneous cannula somewhere on Betty's body, through which she could have been given injections rather than using the oral liquid, which she was no longer able to swallow effectively. Other medications, such as hydromorphone, midazolam, haloperidol and possibly a drying agent for her rattly breathing such as hyoscine butylbromide would also have been suggested and supplied and the family would have been instructed on how to administer this medication. A syringe driver may have been suggested. The family would have been provided with written information on what each drug was for and how often it should be given.

156. All community palliative care services in Brisbane are available on a twenty-four hour basis for phone advice on symptom management and several are also able to provide after-hours home visits by specialty palliative care nurses

157. Dr Syrmis stated the use of a fentanyl patch at the end of Betty's life would not have been recommended by a palliative care service given she was not on any patches in the weeks before her death. Dr Syrmis noted it was not clear in the records who decided to apply the patches but if this was done by the family who were unaware of the dangers involved, then having a nurse visit each day and a palliative care service advice available to the family could have prevented what is assumed to be a mistake.

158. Dr Syrmis stated that if the family had been able to call a palliative care service about Betty's deteriorating condition on 16 July, a specialist palliative care nurse or doctor could have visited at home. If she had already been stabilised on a syringe driver and died peacefully at home, the palliative care service would have assisted in organising a Cause of Death certificate by either the GP or one of the treating palliative care doctors. Moreover a community palliative care service would know the police did not have to be called for an expected death at home, which has been managed appropriately. Hence, the involvement of ambulance and police services could have been avoided. This

would prevent wasting community resources as well as avoiding added stress for the family at the time of the patient's death.

159. Finally, if linked to a palliative care service, Betty and the family would have had access to a multidisciplinary team to care for them during this period. As well as the doctors and nurses, the majority of community specialist palliative care services in Brisbane also have counsellors or psychologists available to support the patient and family before death and support the family or carers in the bereavement period.

160. Dr Syrmis stated in summary, it is Palliative Care Queensland's position that with the involvement of a community palliative care service, appropriate 24-hour support could have been provided to Betty and the family to prevent poorly controlled symptoms at the end of life for Betty. It also may have reduced some of the distress that her daughter recorded at seeing her mother suffering; and prevented administration of medication outside of that which was clearly prescribed.

Conclusions on the issues

161. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the deaths occurred with a view to reducing the likelihood of similar deaths.

162. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body.

163. Betty was an elderly, unwell woman with multiple co-morbidities from which it was possible she would have succumbed over the next few months. When she was discharged home to her family, I accept her medical condition at the time was relatively stable.

164. It is my finding her family did not bring her home thinking she would die in the next few days. The family had gone to some considerable lengths to purchase beds, mattresses and other items and set up their own home in such a manner to provide for Betty's immediate needs.

165. The discharge process was adequately performed by TPCH in the restricted timeline they were given as a result of the family's decision to bring Betty home as soon as possible

.

166. The Post-Acute Care Team was given a referral and I find PACT and the PACT nurse responded appropriately to the referral and made appropriate follow-up. In hindsight, it was unfortunate the family did not avail themselves of the services on offer, but this was clearly a decision the family was entitled to make.

167. A referral was also made to the Palliative Care Service at the request of the daughter. Unfortunately, there was no opportunity for it to provide a service as Betty died within days of the referral being made. The referral itself did not highlight any particular urgency.

168. The ideal situation would have been for the referral to palliative care to have occurred in the hospital and arrangements made at that time. This was not possible, again because of the somewhat rushed discharge.

169. It is now apparent that Betty deteriorated within a day or two of her discharge. It is unclear what the cause of Betty's deterioration was, as she was not seen by any other medical clinician. As Dr Stevenson stated, it cannot be assumed that Betty was in a terminal phase or that there was not some possibility of providing curative treatment.

170. By keeping Betty at home and not bringing her back to hospital or having her seen by a GP immediately, any possible curative treatment opportunity may have been lost, but it is by no means certain there was any curative treatment available.

171. It is difficult to then categorise what was happening next. Was it with palliative intent? If palliative care was intended, it was by no means optimal palliation

practice. There was no direct supervision by a doctor or a palliative care service. Medications were given to Betty by the family and by MB, a family friend and nurse, in a careless fashion which displayed ignorance as to the impact and effects of the medication being given.

172. It is my finding that fentanyl patches were applied at twice the rate stated on the box and were not applied appropriately given there were two patches found on the body at autopsy. Even accepting the odd explanation of the daughter that she thought they were for Betty's heart, this still does not overcome the misapplication of them.

173. I find the fentanyl lozenges had little part to play and the misapplied patches themselves are responsible for the elevated fentanyl levels found at autopsy.

174. As to the oral morphine that was given to Betty, this clearly was in amounts well over what was prescribed. The evidence of the daughter was that over less than 24 hours she gave Betty half a dozen doses when it should have been less than four. Even accepting she misunderstood what was written on the bottle as being not to be given more than four hourly, she still gave one dose at 8am and then gave another dose in the company of MB an hour and half later.

175. I accept the daughter was panicking at the distressed state her mother was in, which is understandable, but it clearly would have been better for her mother to have been assessed by a doctor or a palliative care service, before proceeding to give further and increasing doses of the oral morphine medication. This of course was compounded by the effects of the fentanyl patches, which were not meant to have been applied in the first place.

176. I accept the evidence of MB that she was not aware of fentanyl being given in the way of patches until after she had given the final dose of morphine. This by no means diminishes the impact of her reckless decision to give Betty a substantial dose of oral morphine in circumstances where she knew two doses had been given in the preceding two hours or so. She then exacerbated this erroneous decision by applying a dose that was well over the level set on the bottle of at least twice the amount prescribed and I find was likely to be even greater than that amount. MB made these decisions without obtaining any

medical advice. I am certain if Dr SK had been contacted she would not have amended her order of 1-2ml 3 times a day as required. The excessive doses provided by the daughter and MB are totally consistent with the findings at autopsy and the opinion of Dr McGuire, both of which I accept.

177. Dr SK agrees that in retrospect, it may have been more prudent for her to advise the family to contact an after-hours doctor, who could assess Betty. I accept she was trying to be helpful to the family in difficult circumstances and she was not aware of all of the events that were taking place or of the use of ceased drugs such as fentanyl and oxycodone.

178. As to the conversations conducted by MB with her colleagues and the Hospital hierarchy, clearly they were unusual and warranted further investigation. It is somewhat unclear as to why MB stated what she did in these somewhat colourful terms. The very best one can say in her favour, is she overreacted to the prospect she may have been responsible for Betty's unexpected death. There was some evidence that her exhibited personality was sometimes such that she could be loud and express strong opinions. She may very well believe that a conversation about how we deal with the dying needs to be had, as do many others in the community. However, having a conversation is quite different to taking direct action without medical advice. There were in fact multiple reasons why Betty may have died, some outside of MB's control, but it is not by coincidence that Betty died a short time after a large dose of morphine was provided and this act was a significant factor in her death.

179. The nursing colleagues acted appropriately in referring these conversations to the Hospital hierarchy. They had moral obligations as citizens but more particularly professional obligations as nurses to express their concerns.

180. The actions of the Hospital hierarchy were reasonable and appropriate. The Hospital thought it should at least provide MB with an opportunity to provide an innocent explanation as to her remarks. In hindsight, after hearing from nursing staff, they could have immediately referred the matter to the police. However, I accept these are fine and perhaps difficult judgment calls to make and I am not critical of the decision to question MB in the first instance. The referral to police was then made promptly.

181. It is quite clear that mixed drug toxicity, intentionally and likely ignorantly given, was the predominant factor, which brought about Betty's death at this particular moment. Dr Milne properly opined for his purposes that the cause of death was 'undetermined' because there was some uncertainty about the administration of the drugs found at autopsy. That uncertainty has been clarified as a result of this inquest. I support the opinion of Dr McGuire that the cause of death was due to a combination of significant pre-existing natural disease and mixed opioid drug toxicity, with the latter being the predominant feature in the last 24 to 48 hours of life. The finding as to the cause of death will accordingly be amended by me in this decision and will be reflected on Betty's death certificate held by the Registry of Birth Deaths and Marriages.

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act or referrals under s. 48.

182. I do not consider any referral to the Director of Public Prosecutions should be made under s. 48(2).

183. As to a referral of MB to a disciplinary body under s. 48(4), it is understood from her evidence, and confirmed by a search of the Australian Health Practitioner Regulation Agency (APHRA) database, that MB is not presently registered as a nurse. My usual practice is to provide APHRA and the Office of the Health Ombudsman (OHO) with a copy of my findings in cases such as these, to be considered in case a further application for registration is made. Since the completion of the evidence, I have also received a letter from OHO advising it received a referral from the Hospital regarding MB and in accordance with a Memorandum of Understanding with our respective offices has requested information from me. In this case I will provide that information and a copy of this decision, for its due consideration.

184. Dr SK noted with concern, the actions of the nursing home in providing S8 drugs to the family, particularly in a situation where a medical practitioner had ceased that medication. Dr SK helpfully brought that to the attention of the nursing home. I am satisfied that the nursing home has made appropriate changes to procedures to avoid a similar event in the future and no further action needs to be taken.

185. The labelling of the Ordine medication was mentioned in evidence on the basis of some confusion as to what *3 times a day or as required* meant. It is evident from the evidence of the daughter that she could have been confused, believing she could give more than three times a day, if her mother's condition required this. MB said something similar. It is unclear what further calculating process was adopted by the daughter when she then stated she believed she needed to wait four hours before giving the next dose. Counsel assisting suggested a possible explanation was she was thinking of waking hours.

186. These confusions as to labelling have been previously considered by me in a case involving the labelling of MS Contin, also a narcotic medication. In my 2008 finding, following an inquest into the death of *Dominic Raphael Doheny,* I made the following recommendation:

I recommend that the Therapeutic Goods Administration consider if it should require prescribers or the manufacturers of MS Contin or other strong narcotic medication that the dosage be stated specifically in number of hours between taking the next dose and if there should be clear warnings placed on insert material and on the packet that a failure to take the medication strictly in accordance with instructions may have serious consequences including death.

187. In December 2008, I received advice from the Australian Government in response to that recommendation, indicating that the Therapeutic Goods Administration would take certain steps to strengthen the label warnings both for MS Contin specifically and for other long acting opioid preparations generally, to ensure it was made clear that such medications should not be taken more frequently than 12 hours. In that case, the labelling stated the medication could be given 'twice a day' and the evidence supported a finding that there was some confusion as to whether that meant a double dose could be taken at the same time.

188. Accordingly, I will also ask the TGA if it would consider a similar recommendation *for the prescribers or the manufacturers of Ordine or indeed all other strong narcotic medication that the dosage be stated specifically in the number of hours between taking the next dose and if there should be clear warnings placed on insert material and on the packet that a failure to take the medication strictly in accordance with instructions may have serious consequences including death*.

189. This was an issue that only became evident as a result of the evidence heard at the inquest, and I regret we were not in a position to appropriately notify the TGA of the issue being raised, which would certainly be the preferred option. I accept I have not heard evidence from the TGA as to its thoughts on the matter, hence the recommendation is cast in these terms.

190. Palliative Care Queensland suggested a number of recommendations to assist in the prevention of future deaths occurring in the manner that Betty died. As the evidence panned out during the inquest, the suggestion there may had been some concerns that a referral to a community palliative care service was not actioned appropriately or in a timely matter, were allayed.

191. Accordingly, it is not intended to make any specific recommendations, although I accept the recommendations PCQ suggested highlight what PCQ would consider best practice for the future and I very much appreciate their assistance in this matter. The recommendations of PCQ are attached as a separate annexure to my decision as an educative tool for possible future reference.

192. The message that this case highlights is that the provision of palliative care services in the community by appropriately trained GP and specialist palliative care services, is an important service and therapeutic pathway for those who are dying without any curative options available. Such palliative care must be conducted strictly in accordance with a medical practitioner's advice and written plan and not deviated from except upon medical advice.

193. In this case, there was no written plan or written advice. Although I accept Dr SK would have discussed generally her usual advice concerning the use of medication she prescribed, apart from the prescription advice on the bottle, no other plan had been initiated. This may have occurred a few days later when she attended on the planned home visit. In the interim, the family were left to fend for themselves without any education on medication use and what to expect as their loved one deteriorated. This was not the fault of the GP or the palliative care system, as there had not been sufficient time to put plans in place due to the rushed discharge process. If such a process had been put in place, it is most likely the fentanyl use and its misapplication would have been noticed. Further, more appropriate methods of dispensing medications and the

use of more suitable medications would have been introduced. The family would have been educated on the signs of deterioration thereby avoiding any panic and bad decisions made in a moment of distress. As well, all of the potentially difficult legal and medical implications of what was being planned would have been taken into consideration and a referral to the coroner and this coronial investigation would have been avoided.

194. As Dr Syrmis for PCQ stated, *the involvement of a community palliative care service could have prevented poorly controlled symptoms at the end of life for Betty and also may have reduced some of the distress that her daughter recorded at seeing her mother suffering and prevented administration of medication outside of that which was clearly* prescribed.

195. The message is that palliative care provided in the community must be in accordance with reasonable medical advice. If it isn't then the potential legal ramifications of not doing so are serious. The evidence in this case indicates Betty died in circumstances where she was not provided care that was with *reasonable care and skill, and in accordance with good medical practice.* It was largely family driven, however, I accept it was provided in good faith and there was no intention on the part of the family or MB that Betty would die at that time.

Findings required by s. 45

Identity of the deceased – ES

How she died – ES was an unwell woman with multiple co-morbidities who had been discharged home into the care of her family. A decision had not been made that she should receive palliative care, but it is likely that this would have occurred in the next short while. Unfortunately, she deteriorated within days of discharge. Her family were provided with a GP prescription for oral morphine after requesting pain relief assistance over the telephone. As well, and unknown to the GP, the family had been provided with medication from a nursing home previously occupied by ES including oxycodone and more particularly fentanyl patches. The fentanyl patches were misapplied and excessive doses of oral morphine were provided to ES, which in combination with her co-morbidities resulted in her unexpected death. The excess medication was given in a careless and possibly ignorant fashion and without receiving appropriate medical advice.

Place of death – Brighton, Queensland 4017

Date of death– 16 July 2014

Cause of death –

1(a) Multiple opioid drug toxicity and in particular morphine and fentanyl
1(b) in combination with congestive cardiac failure, emphysema

2. Coronary atherosclerosis, ischaemic cardiomyopathy, chronic kidney disease

Comments and recommendations

It is recommended that the Therapeutic Goods Administration consider a recommendation that the *prescribers or the manufacturers of Ordine or indeed all other strong narcotic medication be directed that the dosage be stated specifically in the number of hours between taking the next dose and if there should be clear warnings placed on insert material and on the packet that a failure to take the medication strictly in accordance with instructions may have serious consequences including death.*

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
7 February 2017