QUEENSLAND COURTS

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Travis Noel GRAHAM**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Toowoomba
FILE NO:	TOOW-COR-0000080/08
DELIVERED ON:	3 September 2010
DELIVERED AT:	Toowoomba
HEARING DATES:	11 August 2010
FINDINGS OF:	Coroner Kay Ryan
CATCHWORDS:	CORONERS: Inquest – Pharmacies filling prescriptions – Seroquel (Quetiapine) overdose – History of attempted suicide – Cancellation of prescriptions

REPRESENTATION:

Counsel Assisting the coroner	Sergeant A Costa
Kylie Duffy (Mr Graham's case manager)	Ms M Fairweather, Minter Ellison Lawyers

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CORONERS FINDINGS AND DECISION

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

1. Introduction

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

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

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

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

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

2. Issues

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

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

- What procedures were in place to ensure that prescriptions discontinued by Mr Graham's treating medical practitioner could not be dispensed?

- Should the quantity of quetiapine (marketed as Seroquel) dispensed at one time be restricted?

3. Social History

Travis Graham was a single man aged 31 years and was unemployed. He had had a troubled past with a history of mental health issues.

He was born in Sydney and had a diagnosis of long standing obsessive compulsive disorder consisting of obsessive thoughts resulting from excessive anxiety and catastrophic misinterpretation of innocuous body sensations. He was diagnosed with this disorder in the late 1990s in Canberra. He was case managed by the Canberra Mental Health Team between 2001 and 2005 and it wasn't until 2006 when it was thought likely he was suffering from a psychotic illness rather than obsessive compulsive disorder. In October 2006 he was admitted to hospital in Canberra having overdosed on *Seroquel* and *Effexor* when intoxicated. He told doctors when discharged from hospital at this time that he didn't want to keep taking Quetiapine (*Seroquel)* as he said it made him hallucinate. He was prescribed *Olanzapine* instead.

It is also reported in his medical history that he used heroin since August 2000 and was started on the methadone program in November 2002. There is also a long history of marijuana use until 2005 when he was prescribed *Benzodiazepine*.

Mr Graham had a history of overdosing on prescription medications, some of which were very serious. On 26 November 2007, he was admitted to Toowoomba Base Hospital, having overdosed on Panamax, *Seroquel* and Benzodiazepines with some alcohol. He suffered an injury to his hand at this time (due to his head laying on his hand whilst unconscious for a long period of time).

In December 2007 he was admitted to Princess Alexandra Hospital in Brisbane for treatment for his hand. On return from Brisbane, he was under the supervision of the Toowoomba Mental Health Service. Dr Ponce became his GP in March 2008 and his next admission to Toowoomba Base Hospital was in April 2008 having overdosed on Warfarin, Fluoxetine, and Olanzapine. He was discharged with "no thought of self harm".

On 2 June 2008, a tentative diagnosis of factitious disorder (Munchausen's syndrome) was made, together with dependent or borderline personality traits and alcohol or drug abuse. It was recognised that he "may go to drastic lengths including non-compliance, deceit, manipulation, and sabotaging of approved treatments simply to access increasing amounts of medical and psychiatric care".

He was offered regular psychiatric contact to counteract his increasing dependency upon medical services. This was designed to dissuade him from attempting overdoses and other drastic strategies. He was also receiving daily injections of *Clexane* to ensure compliance with an anti-clotting agent. The injection was given at Dr Ponce's surgery during the week and OzCare visited Mr Graham on weekends to perform the injection.

4. The Incident

On Saturday 12 July 2008, Ms Schleid from OzCare visited Mr Graham and administered the daily injection of *Clexane*. Ms Schleid gave evidence that when she went to Mr Graham's home on Sunday 13 July 2008, she could not get him to answer the door. She telephoned him on his mobile, but got no answer.

She then left and visited another client and returned to Mr Graham's home about one and a quarter hours later, but still could not raise Mr Graham. She again left to see another client and returned again ½ hour later with no result.

When she returned to her office, she states that she telephoned him again and left a voice message.

Kylie Duffy was Mr Graham's case manager at Community Mental Health in Toowoomba and had been in this role since 18 June 2008. She first met him on 3 June 2008, when filling in for Mr Graham's previous case manager. She conducted approximately nine reviews with him including two reviews with his treating psychiatrist Dr Lim.

Ms Duffy last saw Mr Graham on 9 July 2008 when he attended a review with his treating consultant psychiatrist Dr Lim. Then on 15 July 2008, Mr Graham failed to attend his psychology assessment and on 16 July 2008, Ms Duffy received a telephone call from Grand Central Medical Centre advising that Mr Graham had not attended for his daily Clexane injection.

She made enquiries with Mr Graham's next of kin and his accommodation provider, the Salvation Army. She arranged to meet the accommodation co-ordinator at Mr Graham's flat at 11.40am on that day. Ms Duffy attended at 10.20am and spoke to another resident of the flats, only known as Brendan, who told her he had not seen Mr Graham for several days. She waited for the Salvation Army Co-ordinator to arrive and in the meantime contacted OzCare who reported that Mr Graham received his Clexane injection on Saturday, but that he was unable to be contacted on the Sunday.

When the co-ordinator arrived he unlocked Mr Graham's door and he and Ms Duffy entered to find Mr Graham laying face down on his bed. He had been dead for some time. At autopsy, it was found that Mr Graham died as a result of an overdose of quetiapine with alcohol. Quetiapine is marketed as the medication *Seroquel*.

5. Pharmacy procedures

Mr Graham went to the Discount Drugstore in Grand Central on 17 June 2008 and had a prescription for *Seroquel* 200 mg filled. At that stage, of 5 repeats, there were 4 left. He then went to the Discount Drugstore at Gardentown on 8 July 2008 and had the prescription filled again. This was the 4th repeat, and there were 2 left to go on the prescription. Ms Morgan and Ms Bentley, the pharmacists from the Grand Central Discount Drugstore and Gardentown Discount Drugstore respectively, gave evidence. The original prescription

was what is known as an authority prescription and had been issued by Dr Graham Michael on 20 November 2007.

An authority prescription is one which is authorised by the Federal Government to enable patients to access expensive medications at a reduced cost. The authority does not have anything to do with the potential for a drug to be abused or "doctor shopped" such as benzodiazepines and other opiate drugs. A prescribing doctor must contact the Health Insurance Commission (Medicare) to seek authorisation, including an authority number, to issue such a prescription. Where a doctor regularly prescribes a certain drug, he can receive from the Health Insurance Commission a "streamline authority" which means he/she does not have to obtain a separate authorisation each time such a drug is prescribed.

Both pharmacists described the process in dispensing medications in accordance with a prescription presented to the pharmacy. The pharmacy is "online" in real time with Medicare Australia at all times. When a prescription is presented to be filled, the person dispensing enters the details into the computer directly to Medicare to obtain authorisation for payment. If there is a question with regard to, for example, the patient's health care card, this can be flagged by Medicare with a yellow flag and enquiries are made by the pharmacist.

Ms Morgan agreed that having a database detailing the prescription history of each patient would be of great assistance to pharmacists in dispensing drugs of concern. She advised the inquest that the only database available at the moment was the pseudoephedrine base which had been introduced by the Pharmacy Guild of Australia.

She was further of the view that patients who do take *Seroquel* are patients who are most at risk and that any medication prescribed should be monitored.

Ms Bentley advised that electronic prescriptions are currently being introduced, although she has not dispensed any as yet. Such a prescription has an electronic bar code which will enable pharmacists to track the history of a prescription's dispensing and to see where the next dispensing comes within the process.

Ms Bentley was not aware of any process in place to deal with cancellation of prescriptions. She could see no reason why a system could not be easily put in place to flag an authority prescription as red where a prescription had been cancelled by the doctor when checking the dispensing of medications through the existing Medicare database. The doctor would simply have to telephone the HIC to advise that the prescription was cancelled and this could be done. The pharmacist would then not dispense the medication.

Neither of the pharmacists knew about the prescription dispensed by the other. There is no protocol in place to warn pharmacists when similar prescriptions are dispensed to the same patient on the same day or within a short period of time.

Seroquel is not a drug of addiction and has recently been recognised as a drug with some street value. Product information for *Seroquel* reveals that a lethal dose could be as low as 13 g. It is dispensed in packets of 100 mg, 200 mg or 300 mg of 60 tablets each, meaning that ingestion of one packet of 300 mg *Seroquel* could be sufficient to cause death.

In this case, the prescription was for *Seroquel* 200 mg and Mr Graham had 2 repeats dispensed within 3 weeks.

6. Doctors' consultations

When Mr Graham moved to Toowoomba in 2007, he was under the care of Dr Graham Michael. On 20 November 2007, Dr Michael added *Seroquel* 200 mg 1 daily to his prescriptions. At the inquest, Dr Michael stated that he had prescribed Mr Graham *Seroquel* as he believed it was a continuation of something which had previously been prescribed. A perusal of the available medical records indicates that Mr Graham had last previously been prescribed *Seroquel* in Canberra in 2006, but this was ceased following an overdose and Mr Graham's complaint that the medication caused hallucinations.

As stated above, he was admitted to Toowoomba Base Hospital on 26 November 2007 having overdosed on Panamax, *Seroquel* and benzodiazepines with some alcohol.

Dr Michael's records then reveal that he saw Mr Graham on 29 November 2007 when the *Seroquel* was "ceased". There is no mention of the overdose some three days earlier.

As a result of investigations undertaken during preparation for the Inquest, Dr Michael was asked whether the reason the *Seroquel* was ceased was because Mr Graham had attempted suicide. Dr Michael's response in his letter to the Coroner (Exhibit 22) was that the *Seroquel* was ceased "because the drug caused Mr Graham considerable nausea".

When asked during his evidence at the inquest as to how he ensures that patients do not have "cancelled" prescriptions filled, Dr Michael stated that there was an implicit contract between the patient and the doctor. As part of that contract, the doctor asks the patient to destroy the prescription and repeats and expects that this will be done in good faith.

He stated that the only indication the doctor would have that the patient had not destroyed the prescription, would be if the pharmacist telephoned to ask questions about the prescription, for example, dosage.

When pressed as to whether a doctor could telephone the Health Insurance Commission (Medicare) to advise that a prescription was cancelled, Dr Michael was hesitant to agree that this could be done. He did point out that where authority prescriptions are concerned, there cannot be two authority prescriptions, with the first in time being cancelled if another is issued. Further an authority prescription is cancelled if the dosage is changed.

Dr Michael described the common effects of *Seroquel* as dry mouth and eyes and twitching. Anecdotally, he stated that there was an increasing trend for recreational use of *Seroquel*.

He went on to describe the new technology which is emerging with regard to E-health where there has been a trial in the Northern Territory. Prescriptions are created electronically and digitally signed. If this technology is introduced nationally, then the cancelling of prescriptions will be easily done. This appears to be in accord with the evidence of the pharmacists.

Dr Ponce, who was Mr Graham's general practitioner from about March 2008, also gave evidence. Dr Ponce stated in evidence that she would not normally prescribe drugs such as *Seroquel* without first consulting with the patient's treating psychiatrist.

If she were to wish to cancel a prescription, she stated that she would contact the Pharmaceutical Benefits Scheme and enquire with a view to putting a hold on any prescription being dispensed at pharmacies.

7. Findings

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

(a) The identity of the deceased person is Travis Noel Graham.

(b) Mr Graham died of an overdose of quetiapine (contained in the medication *Seroquel*) in combination with alcohol. This was the finding at autopsy and I agree with that finding.

(c) Mr Graham died on 13 July 2008.

(d) Mr Graham died at his home at 1/71A Kate Street, Toowoomba.

(e) Mr Graham's death was caused by -

- his taking at least 100 - 200mg tablets of *Seroquel* with alcohol. *Seroquel* 200mg and 300mg is manufactured and supplied in packets of 60 tablets – potentially 12g to 18g. A fatal dose has been reported as being as low as 13.6g of this medication. It would appear from the evidence (empty blister packs of *Seroquel* found at the scene) that Mr Graham took the equivalent of 20g of *Seroquel* with alcohol.

  Whether this was taken deliberately or as a cry for help is unclear. I am unable to conclude that he took his own life deliberately, although he did have a history of overdosing on prescription medication.

- Dr Michael prescribed *Seroquel* 200mg to Mr Graham on 20 November 2007 and supposedly "ceased" the prescription on 29 November 2007 "because the drug caused Mr Graham

considerable nausea". Dr Michael did not take any steps to ensure that Mr Graham did destroy the prescription. He did not notify the HIC that he had "ceased" the authority prescription; he did not ask Mr Graham to return the prescription; and he did not notify Mr Graham's new general practitioner of the outstanding prescription.

I therefore find that the omission by Dr Michael to take any positive action in ensuring that Mr Graham was unable to have the prescription further dispensed, especially in light of the overdose on the same medication prescribed by him on 26 November 2007, contributed to Mr Graham's death.

8. Recommendations

It is recommended that –

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

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

(c) the Federal privacy laws be amended to enable PBS information about a patient to be disclosed to the approved supplier of medication to that patient.

(d) where concerns are raised with regard to authority prescriptions or such prescriptions are to be cancelled or withdrawn, that prescribing medical practitioners immediately advise the Health Insurance Commission, so that an alert can be raised on the Health Insurance Commission (Medicare) database which is available to all pharmacists in real time when dispensing medications.

(e) a process be developed to ensure that prescriptions which have been cancelled or withdrawn by a treating medical practitioner are returned to the medical practitioner or destroyed, to prevent such prescriptions from being presented by patients to be dispensed.

Kay Ryan
Coroner