OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dominic Raphael Doheny**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO:	COR00001818/05 (8)
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FINDINGS OF:	Inquest
CATCHWORDS:	CORONERS: Inquest – Morphine toxicity, MS Contin, Warning labels

REPRESENTATION:

Ms Julie Sharp Counsel Assisting the Coroner

Mr Richard Perry SC instructed by Sparke Helmore
Representing Dr Mammino

Mr Morgan of counsel instructed by Guild Lawyers
Representing Ms Grant

Mr Schneidewin instructed by White Jordan
Representing the family of Mr Doheny

CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the death of Dominic Raphael Doheny who died at his home on 29 August 2007. The cause of death according to a pathologist was morphine toxicity. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*[1] provides 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 findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

2. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

    a) whether a death in fact happened;
    b) the identity of the deceased;
    c) when, where and how the death occurred; and
    d) what caused the person to die.

3. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

4. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [2]

5. 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 death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or any comments or recommendations,

[1] *Coroners Act* 2003, s45
[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46

statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[4]

The Admissibility of Evidence and the Standard of Proof

6. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[5] That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

7. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

8. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

9. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

10. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that information may cause a disciplinary body for a person's profession or trade might inquire into or take steps in relation to that person's professional conduct, the coroner may give that information to that professional body.[11]

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[4] s45(5) and 46(3)
[5] s37(1)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168
[11] S48(4)

The Evidence

11. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

12. Mr Doheny died at home on 29 August 2007. He was born on 27 December 1970 making him 36 years old when he died. The cause of death according to the pathologist, Dr Ong was morphine toxicity.

13. Mr Doheny was married to Tristan Jacqueline Doheny. They had known each other since childhood and married in 1998. They had two children, Jasmine aged 7 and Jarvis aged 5.

14. Mr Doheny's wife states that her husband had a history of respiratory problems having worked as a labourer in dusty environments and with asbestos. She describes him as being a very big man. The autopsy report notes he weighed 180kg and he would be in the category of morbidly obese. He snored at night. He possibly had sleep apnoea. There were two hospital admissions about three years prior to death on account of "*coughing spasms*". Mr Doheny's general practitioner since childhood was Dr Mammino. He had been prescribed ventolin and a vaporiser at one time. His wife says this assisted his breathing at night. No formal diagnosis of asthma or of sleep apnoea had been made. In relation to the latter, his General Practitioner had made a referral to a sleep clinic but Mr Doheny had not attended. There is some suggestion he did not always follow medical advice and therefore may be at a risk of being non-compliant with medication instructions, but there is no suggestion that he was not capable of understanding instructions regarding medication.

15. On the Friday prior to his death Tristan Doheny noticed her husband was unwell. He was coughing and appeared to have the flu. Over the weekend Mr Doheny was short of breath, coughing and complaining of pain around his rib cage. Mrs Doheny sought help from Mr Doheny's cousin, Faith Wood who has nursing experience. She came to stay to help care for Mr Doheny whose symptoms were worsening.

16. Mr Doheny went to the RBH emergency department in the early hours of the morning on 28 August 2007.It seems he drove himself there and back and had not told his wife or Ms Wood. He presented with left side pleuritic pain and was seen by Dr Mansfield. The hospital notes indicate that a thorough examination was conducted and investigations included a chest x-ray, an ECG and blood tests all of which returned normal results. The "*working diagnosis*" was musculoskeletal pain secondary to excessive coughing. Ten(10)mg of morphine was administered at 1.30am and a further 5mg at 5.00am. Dominic left the hospital around 6.30am with a script for Brufen, a letter for his GP and a medical certificate. He had told Ms Wood in a telephone conversation whilst he was at hospital that his pain had not subsided by much with the first two

doses of morphine and later when he saw her he said he was still in pain.

17. Mr Doheny presented to his GP, Dr Mammino that afternoon and was prescribed Augmentin Duo Forte for treatment of the cough and MS Contin for severe pain. He was also given a script for Lazic. Dr Mammino states that he wrote in his notes that he was prescribing 60mg MS Contin tablets whereas the script clearly indicates 100mg to be taken 'bd'. This is a medical abbreviation for twice a day. Dr Mammino's prescribing instructions which were placed on the packet by the pharmacist was that "One tablet to be taken twice a day". Product information warns that MS Contin 100mg should only be prescribed for morphine tolerant patients and that such patients should be provided with clear instructions about the dangers associated with taking the medication other than as prescribed. The family contend that Dr Mammino should not have prescribed MS Contin 100mg at all.

18. I will deal with what happened over the period from his return from Hospital to around 11 am the next day shortly. At around 11.15 am his family noticed he was not breathing and commenced CPR. An ambulance was called. While there is a suggestion on the evidence of Faith Wood that there was up to a half hour delay in calling the ambulance, the evidence from his wife and Jeannette Klaer was that as soon as Dominic was discovered not breathing an ambulance was called. Queensland Ambulance records indicate that the call was made at 11.16 hrs and two units dispatched with the first arriving at 11.24 hrs and the second at 11.27 hrs. He was pronounced deceased at the scene. I accept therefore that he was found by family members around 11.15 as distinct from closer to 10.45.

19. Faith Wood came to the house on the Saturday. This was a regular practice. Although Mr Doheny had some possible early dyslexia problems she says he could read and write well and would have no trouble understanding instructions from a doctor. She came over on 26 August and she stayed there that day and on the Sunday. Ms Wood stayed mainly to help Tristan with the children and because Mr Doheny was in a lot of pain.

20. Ms Wood says she became aware that Mr Doheny had taken himself to Royal Brisbane Hospital in the early hours of the Monday 28 August. She spoke to him at the hospital. He drove himself home. She says he told her that he had been given morphine 3 times in hospital. He came home early that morning at 7am. She drove him to Dr Mammino for an appointment at 3pm and she noted that he came away with a prescription for MS Contin 100mg tablets. She had waited in the reception area whilst the consultation took place.

21. They attended a pharmacist who filled the script. Her evidence is the female person who attended them was in her early to late 20's with long blonde hair in a pigtail (later clarified to be a ponytail) and in a pharmacy

uniform. She says the pharmacist simply asked him if he had taken MS Contin before and he said he had. This would appear to be the case as Dr Mammino says it was prescribed to him earlier that year for another procedure. Ms Wood says that no other matters were discussed by the pharmacist and no warnings were given.

22. The issue concerning what was said or not said by the pharmacist when the MS Contin was handed over was of some significance and controversy. Ms Grant is aged42 and has been a pharmacist for 20 years. She does not look like the person described by Ms Wood. Ms Grant does not recall the events of 28 August 2007 but has had recourse to the business records of the pharmacy which would indicate that she was the pharmacist on duty and was the person who dispensed the prescription. She also dispensed a prescription for Augmentin Duo Forte and Lasix. Her evidence is that she would have made a number of enquiries about adverse reactions to any medications previously. As to MS Contin she would have warned him not to drive and taking into account the time of the day that he should take the Augmentin before the evening meal and the first MS Contin after the evening meal and the next one the following morning with breakfast.

23. Ms Grant also noted from the records that earlier in the day a script for Brufen had been dispensed for Mr Doheny. These records were subsequently produced.[12]

24. This was a script issued by the Hospital earlier that morning. The pharmacist who dispensed that script was Michelle Duncan who Ms Grant describes as being in her late 20's with blonde hair at shoulder length which she sometimes wears in a pony tail style. Mrs Doheny gave evidence that she and Faith went to the same pharmacy earlier in the day after her husband had come from the hospital to pick up the Brufen and left Mr Doheny at home.

25. Ms Wood was recalled to clarify her evidence. She had been present in court when Ms Grant gave her evidence the previous day. She says she has no recollection of having seen Ms Grant previously and she considers she has a good memory for faces. She concedes she must have been mistaken as to her recollection as to who served them in the afternoon and Ms Duncan must have been the person who served them in the morning. She says that Mrs Doheny was also asked the same question by the pharmacist as to whether Mr Doheny had taken Brufen before. She was adamant that in the afternoon the conversation was still only limited to whether he had used MS Contin before and nothing else. She cannot describe that person now at all.

26. I accept the evidence of Ms Grant and would find that she did speak to Mr Doheny in terms of what would have been her usual practice. I accept Ms Wood was giving honest evidence and in the circumstances

[12] Exhibit F4B

is mistaken or confused about the events of the day, and understandably so. The events of this day must have been distressing for the whole family. I am confident that this explains what appeared to be conflicting versions between Ms Wood and Ms Grant and that the evidence given by Ms Wood as to the dispensing related to the earlier occasion when the Brufen was dispensed by Ms Duncan.

27. Morphine is a Schedule 8 Controlled Drug and a statement from Adam Griffin, Forensic Medical Officer with Queesnland Health's Clinical Forensic Medicine Unit indicates that prescribing and dispensing requirements were not followed however the evidence would indicate that the script was legal. Ms Grant understands Dr Mammino's handwriting and the issue raised by Dr Griffin was addressed in evidence and I have now no concerns as to the legality of the dispensing by the pharmacy.

28. Ms Wood says that she saw Mr Doheny take one MS Contin tablet whilst they were at the car coming home from the pharmacy. This is likely to have been close to 5.30pm. She says that Mr Doheny appeared to be much better later on. Later that evening at about 8.30 pm she says he told her that he had taken another MS Contin and she saw he had a glass of scotch in his hand. He was apparently pain free and he was smiling. She counselled him in strong terms about not taking any more. At 10 pm he reported he was also fine and she again counselled him not to take any more MS Contin. She says she was firm about this with him, that he agreed with what she said and he was alert and seemed to understand.

29. At midnight she was woken by Tristan who asked her if he could take another tablet as he was complaining of pain. She told them both, again in strong terms, that he could take the Brufen but no more MS Contin. Ms Wood describes Mr Doheny at that time as drowsy and confused. He was standing but unstable. Tristan also says he appeared confused and drowsy and that he was not happy that he could not take another MS Contin and "that he really wanted one."

30. During the night Ms Wood heard him snoring where he was sleeping on the couch and he continued like this for a number of hours. Her last recollection of seeing him snoring and his chest rising was at 9.45am. Ms Wood tried wake him up and he was not breathing. She said this was at 10.45 but as stated earlier it is likely to be closer to 11.15. CPR was commenced and the ambulance was called and he could not be revived.

31. There is no direct evidence from witnesses who saw Mr Doheny take all of his medication. Ms Wood saw him take one MS Contin at about 5.30pm. He told her at about 8.30 pm that he had taken another and at midnight he was anxious to have another. She told him he could have a Brufen on both occasions. We know he had some Brufen from the Hospital and she saw him take two more when he came home early in the morning. After that his wife and Ms Wood collected a prescription for

Brufen. At midnight his wife says he took 2 more Brufen and he wanted to take more MS Contin. Photographs taken by police of the medication show that of the Augmentin, none has been touched, only 2 Brufen have been taken and 3 MS Contin have gone.

32. On the basis of all the evidence I am satisfied to a high degree of probability that between 5.30 pm and around midnight, being a period of say some 6 hours, that Mr Doheny had taken 3 tablets of MS Contin. This was contrary to the prescription packet, the instructions of the pharmacist and the warnings by Ms Wood during the evening.

33. Dr Mammino's statement notes that he prescribed MS Contin 60mg for one to be taken twice a day. He noted he weighed 180kg and had been prescribed MS Contin earlier that year. He agrees he received a letter from the Hospital which stated he had been given 15mg intravenously earlier that day consistent with the advice in the hospital letter. He no longer has the letter but transcribed it in his records. His records indicate he prescribed 60 mg of MS Contin. The script however has written 100mg of MS Contin. He is unable to explain why that is or what his intention was at the time of prescribing.

34. Dr Mammino's notes indicate that in February 2006 he saw him with symptoms of sleeping poorly and lethargy. He was snoring and DR Mammino had concerns it could be sleep apnoea. He was referred to the Sleep Clinic at The Prince Charles Hospital. It seems Mr Doheny did not attend and later told Dr Mammino he was too busy. This was not the only time that Mr Doheny had not followed through on referrals and advice. Dr Mammino said that as far as he was concerned a diagnosis of asthma and sleep apnoea were never proven.

35. He had previously given Mr Doheny the drug Endone, a short acting narcotic for pain relief on a previous occasion and Mr Doheny reported it had little effect. He agreed that Mr Doheny could not be considered opiate tolerant. He decided to prescribe 100mg MS Contin because of the severity of the pain, his weight and his previous experience of little effect from Endone. Dr Mammino was not aware and his notes do not reflect any previous problems with MS Contin. There is some evidence from Ms Wood that he had vomited previously with the drug. That is of course a known adverse reaction to the drug.

36. Dr Mammino said he would have told him to take one tablet at night and one in the morning, that he should not drive, that he may get drowsy, feel sick and to not drink alcohol. He also said he considered him to be a healthy man and he was working which was evidence of that. He had done a respiratory test and his Peak Flow Rate was not markedly down on 17 August 2006. His chest X rays taken at hospital that day showed no signs of respiratory issues so he did not consider the cough a respiratory problem.

37. He disagreed with the opinion of Professor Drummer that a single dose of 100mg can be fatal and pointed to prescribing information which suggested it would have to be over 120mg. He did not accept that it was a high risk dose as he considered his excessive weight a significant factor. He disagreed with the opinion that weaker opiates such as Tramadol or Codeine could have been used. Tramadol was very weak and Codeine was weaker that Endone. He disagreed with the assertions made by Professor Drummer and similarly he disagreed with the view of Dr James that MS Contin should not be used for acute pain because it is slow release and the effects would not be felt for many hours. Dr James says it is used more for those with chronic pain. He also disagreed with the assertion of Dr James that it is generally started in much smaller doses even for a man his size.

38. The family's solicitors commissioned a report from a general practitioner, Dr Raewyn James, who is critical of Dr Mammino prescribing as he did. It is clear from her evidence that she would not prescribe this drug for a patient presenting in the same circumstances. She said in her report that she considers 100mg of MS Contin is a large dose for an opioid naïve patient and there would be side effects. Importantly she also said that taken twice daily as prescribed there would be a low risk of death. She clinically would have used other medication which would give a rapid onset to pain and to that extent she agrees with other medical evidence from Professor Drummer and Dr Griffin. One of her concerns with MS Contin is that it is slow release and she tells patients that they may not feel much effect with the first and to counsel them to stick to the prescribing conditions. She has concerns that patients may take more tablets when they do not get the initial relief. She therefore takes a cautious approach to its use. She agreed to the suggestion that given the various factors that faced Dr Mammino you could mount a good argument to use MS Contin and it was a difficult choice.

39. Dr Adam Griffin from the Clinical Forensic Medicine Unit also gave a report. He also would not go down the slow release path for acute pain and would try other things first. He would have tried anti-inflammatories first. Given the evidence that Brufen had not worked; that there was severe pain; that Endone had not been effective in the past and other issues he agreed that the doctor was in a difficult situation when he prescribed MS Contin although he still says it was not the safest option. He also noted the report from the family that some 3.5 hours after the first MS Contin he was reported to be pain free and on that basis the tablet had done its job. Dr Griffin as with Dr James expressed surprise therefore as to why he took another as presumably he did not need it.

40. Professor Olaf Drummer is the Head of Forensic and Scientific Services at the Victoria Institute of Forensic Medicine. He is a forensic pharmacologist and toxicologist and has been involved in the analysis of drugs and poisons and in the interpretation of their biological effects for

over 25 years. Professor Drummer provided a report to the Coroner[13] and gave evidence.

41. He noted that Mr Doheny would be categorised as opioid naïve with no tolerance to morphine. High doses would be therefore much more likely to have been life threatening than in those with an established tolerance to opiate-like drugs.

42. Professor Drummer described the pharmacology and toxicology of morphine. It is a narcotic analgesic normally used for control of severe pain. Usual oral doses of morphine range from 5 to 30 mg, although much higher doses can be tolerated in tolerant persons given in divided doses or by infusion.

43. Morphine produces sedation and analgesia, however the extent of these symptoms and any adverse symptoms depend on a range of factors including dose and any tolerance developed to this or related drugs. At higher doses it may also produce side-effects such as sweating, vomiting, low blood pressure, pin-point pupils and can adversely affect respiration and cause pulmonary oedema.

44. Morphine is metabolised to 3- and 6-glucuronides, which are present in both blood and urine. When blood is treated with enzymes, or with acid to hydrolyse these conjugates, the resulting morphine concentration is referred to as "total morphine". This represents both free (unconjugated morphine) and conjugated morphine. Total morphine concentrations in blood are invariably higher than free morphine.

45. Morphine is removed with a half-life of about 2-3 hours in most persons. This means that after about 6 hours relatively small amounts of morphine remain from a previous dose (about 25%). Within 12 hours effectively no drug is left.

46. Morphine concentrations post-mortem can vary somewhat from peri-mortem levels due to varying quality of blood and due to small increases from redistribution. Increases are usually less than 50%. Free and total morphine concentrations following therapeutic use can range well beyond 0.1 mg/kg but this is usually associated with higher doses or chronic treatment.

47. Toxic concentrations depend on the body weight, degree of tolerance, the route of administration and the frequency of administration, as well as the presence of natural disease and use of other central nervous system (CNS) depressant drugs. There is significant variability amongst individuals as to a toxic dose. Individuals who are healthy or who have used opioids regularly beforehand often require larger doses.

[13] Exhibit C3

48. There is no defined concentration that can be regarded as absolutely safe, that is, there is no defined therapeutic concentration for this drug. Low blood morphine concentrations can cause respiratory depression, particularly in opioid-naïve persons. This could be caused by single oral doses as low as 50 mg (or even lower).

49. Professor Drummer described the effect of slow release morphine tablets (or sustained release) such as MS Contin. They are designed to allow morphine to have an effect for at least 12 hours. At 12 hours there will still be morphine present from the previous dose. They are designed to provide 24-hour coverage of pain relief if tablets are taken every 12 hours.

50. Sustained release morphine such as in MS Contin will take some hours to absorb, and Professor Drummer said the time to maximum blood concentration averages about 5 hours, but could be somewhat shorter or longer. The consumption of a further tablet at 2030 hours should not have occurred since the previous dose was still being absorbed and would not have had its maximum effect. The consumption of a further 100-mg tablet at midnight further complicated the situation for Mr Doheny because the previous doses would not have been completely absorbed, and even the first oral dose would still be having an effect.

51. Professor Drummer stated that in those circumstances he was not surprised that Mr Doheny died from the toxic effects of morphine.

52. He further stated that the prescribing of 100-mg SR morphine should be seen as a high risk dose, even in the circumstance of a morbidly obese person. The presence of bronchitis and/or asthma, and/or presence of sleep apnoea would have further increased his risk of respiratory distress to morphine.

53. Like Dr James and Dr Griffin he questioned why such a strong narcotic analgesic was prescribed as there are weaker opioid-like drugs that arguably could have provided temporary relief, ie codeine, or even tramadol. He also agreed that it may be a risky dose but this needs to be balanced with the need for pain relief.

54. I have not seen if there was a package insert with the MS Contin packet. It was not located by police but then they may have missed it. The lawyers for the family have provided what is referred to as the standard package insert from their research which notes MS Contin 100 and 200mg are for use opioid tolerant patients. It states that these tablet strengths may cause a fatal respiratory depression when administered to patients not previously exposed to opioids.

55. The product information which was tendered as part of exhibit A3 is not a specific as that although it refers to the range of tablets from5mg to 200mg. The prescribing information found on MIMS Online which was also tendered would also give some support to the views of Dr James

and Griffin on the basis it should be restricted to situations where all other conservative measures have been tried and failed. It however says that MS Contin 200mg should only be used in opioid tolerant patients. It does not say this in relation to 100mg doses. It does not specifically refer to fatal respiratory depression as such. I note that in all the literature that the usual dose is “one every 12 hours and taken strictly according to instructions.” In my view that instruction is more specific than simply one tablet taken twice daily and I will recommend that this should be considered as standard practice in the future.

56. In my view there does need to be a rationalisation of the advice contained in these various publications. Further the use of the prescription dosage of 1 tablet twice a day could be better set out as one tablet every 12 hours and with a specific warning on the packet that taking more than the prescribed dose can be fatal. I will send these findings and my recommendation to the Therapeutic Goods Administration for its consideration.

The Autopsy

57. Dr Beng Beng Ong performed an external and full internal autopsy examination, and took toxicology samples.

58. Dr Ong noted his weight and that he was classified as morbidly obese. There was an area of extensive contusion in the lower left chest region consistent with the history of pain and a suspected pulled muscle. No significant pathology was found which could account for his death.

The toxicology report reveals the following –

Morphine –	0.07mg/kg
Total morphine (morphine + morphine glucuronides)	0.41mg/kg

59. Dr Ong said that the level of morphine especially that of total morphine was in the known toxic range. The typical mechanism of death is respiratory depression. Dr Ong found that the cause of death was morphine toxicity and that the sedating effect of that drug was likely to have been exacerbated by sleep apnoea which is a condition which is common in obese persons who have impaired breathing during sleep.

Findings required by s45

60. Dominic Raphael Doheny was prescribed 100mg tablets of MS Contin. The family say he should not have been given such a prescription and this is what caused his death.

61. Drs Griffin and James would not have done so, at least until other drugs had been tried. Although there are known risks of the drug, if used in accordance with instructions death is not an expected outcome. They however both conceded that there was also an argument that could support the use of 100mg MS Contin. It is a clinical decision and although I accept their view I can also accept that Dr Mammino's decision was clinically supportable. Dr Mammino may want to consider the circumstances in which he prescribes it in the future and should undertake further clinical education in relation to the prescribing narcotics, however after some consideration of the evidence I do not consider that this is a case where I should take any further action such as referring it to the Medical Board of Queensland for investigation as to any disciplinary proceedings. I will forward a copy of my decision to the Health Quality and Complaints Commission for the purpose of its information in monitoring any trends it may come across in the prescribing of such medication.

62. Mr Doheny was pain free a few hours after taking the first tablet so it apparently worked. It is surprising that he would then take a second tablet with alcohol even though this is warned against on the packet. I find he was given the usual warning about its use by Ms Grant. He had been given some similar advice from Dr Mammino. Ms Wood gave him some vigorous advice at 8 pm and then at 10 pm and then at midnight. He took one tablet at around 5.30, another around 8.30 pm and then another around midnight. It is unlikely and it has not been suggested that Mr Doheny could have been mistaken as to the time limits for taking the drug. However, even if he thought that one tablet twice a day meant he could take two at any time in the 24 hour period, this does not explain why he took three. He may have been in a confused state at midnight when he took the third tablet but he did. It was the total quantity of MS Contin that ultimately caused his death.

63. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Dominic Raphael Doheny's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

    (a) The identity of the deceased was Dominic Raphael Doheny
    (b) The place of death was 838 South Pine Road, Everton Park, Brisbane, Queensland.
    (c) The date of death was 29 August 2007.
    (d) The formal cause of death was:
        1(a) Morphine toxicity.

Concerns, Comments and Recommendations

64. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

65. **Recommendation 1**

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.

Recommendation 2

That Dr Mammino undertake further clinical education in relation to the prescribing of narcotic medication.

Recommendation 3

That the Health Quality and Complaints Commission note the findings and evidence in this case for the purpose of monitoring any trends in the use of prescribed narcotic medication.

My condolences are expressed to the family of Mr Doheny. I close this inquest.

John Lock
Brisbane Coroner
12 September 2008