QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Katie Lee Howman**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2013/4563
DELIVERED ON:	27 July 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 January, 19, 23 & 24 February, 2015
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Inquest – Opioid dependency of heath care practitioner (nurse) Oxycodone, tramadol and fentanyl Supervision by AHPRA, Doctor shopping Accessibility to real time information of doctor attendances and prescriptions

REPRESENTATION:

Counsel Assisting:	Mr Anthony Marinac, Office of the State Coroner
Dr Leslie Dhaniram	Ms J Rosengren of Counsel I/B K & L Gates

Dr Ross Phillipson	Mr H McCay, of Avant Law
Queensland Nurses Union	Ms S Robb of Counsel I/B Roberts & Kane Solicitors
Australian Health Practitioner Regulation Agency	Ms Stephanie Gallagher I/B Corrs Chambers Westgarth
Darling Downs Hospital and Health Service and Dr Peter Gillies	Mr C Fitzpatrick of Counsel I/B Minter Ellison Lawyers

Introduction

Katie Lee Howman was a happily married young mother of two children who worked as a registered nurse in the critical care ward at Toowoomba Base Hospital[1]. On the last Saturday morning before Christmas in 2013 her husband, Heath, discovered Katie deceased in the ensuite bathroom at their home. He had left home early on 21 December to do a few hours' work before a planned family social engagement. They were to drive to Warwick for the day and meet up with close friends who lived interstate. It was the first day of a two week period of leave for Katie from her work.

When Heath returned home shortly after 10 that morning he was met by his older child who was very upset, saying that mum was locked in the bathroom and the child could not get in. The younger child was crying in a cot and Heath was immediately alarmed that something was wrong.

Katie did not respond to his calls at the bathroom door and he forced the lock to enter. He found Katie lying in an unresponsive state on the floor. There was a syringe and needle beside her, which he removed. He immediately called the ambulance and commenced cardio pulmonary resuscitation. Ambulance officers arrived promptly but Katie could not be resuscitated and she was declared deceased. She was thirty years of age.

Autopsy

Autopsy examination was performed by the forensic pathologist Dr Roger Guard. The only injury discovered was an intravenous injection site on her left wrist. There was no evidence of disease to account for her sudden death.

Final toxicology results established that Katie Howman died due to an overdose of the opioid drug, Fentanyl.[2] No other opioids were detected. Other evidence established that Fentanyl was not a medication that had been prescribed for her. An anti-depressant, (citalopram) and an anti-convulsant, (levetiracetam) were detected together with an over the counter anti-inflammatory medication (ibuprofen).

The other significant finding at autopsy was the microscopic examination of lung tissue which showed crystalline granulomas adjacent to blood vessels. Dr Guard interpreted this finding as evidence that the deceased person "was an intravenous drug abuser. The histology showed a foreign body giant cell reaction around crystalline material in small vessels."[3]

This conclusion was subsequently explained at the inquest by Clinical Forensic Medicine Unit doctor, Gary Hall.[4] It was noted the samples which revealed granulomas were from four sections of upper and lower, left and right lungs, and

[1] Critical Care Ward encompasses intensive care unit, high dependency unit and coronary care unit.
[2] Fentanyl was measured at a level of .018mg/ kg. The reported lethal level quoted in literature was between .003 and .028mg/kg.

[3] Page 3 Autopsy report Ex A2

[4] The pathologist Dr Guard was deceased by the time of the inquest.

therefore considered to be widespread.[5] Dr Hall stated a granuloma is a reaction the body has to a foreign material, whether it be a bacteria or an inorganic material such as talcum powder…..when a material gets into the blood stream that the body cannot destroy by white cells totally destroying it, or the liver clearing it out, the body will develop literally like a scar tissue around that substance,…to wall it off….A crystalline granuloma will be a granuloma or scar tissue reaction around a crystalline substance.[6]

Dr Hall explained the granulomas in the lung were most likely due to intravenous drug use rather than other sources. If you inject a drug into a vein it goes to the heart which pumps it to the lung which filters out fine materials. This was compared to a substance that might have been taken orally which could enter the blood stream. This would be filtered by the liver and granuloma particles would be in the fat in the liver. He concluded because the granulomas were in the lung it meant that access was through a vein. As these granulomas showered the whole lung it was more likely to have been due to intravenous use rather than if a substance or organism had been inhaled. These granulomas had developed from repeated use due to the amount of scarring formed by a conglomeration of giant cells. Dr Hall concluded this evidence meant a long process for the body to develop this response indicating repeated use of intravenous drug(s).

There was no direct evidence from the autopsy of what the crystalline substance actually was. [7] There was only evidence of two instances of known intravenous administration of Fentanyl, but the inquest also had available evidence of a large quantity of prescribed opioid medications over a significant period of time. This will be discussed later.

Dr Hall noted the findings at autopsy were typical for people who had died as a result of opiate overdose.

He analysed the toxicology result from which Dr Guard concluded Mrs Howman had died due to Fentanyl overdose. He agreed with this conclusion,[8] qualified by stating that the level of Fentanyl was on the lower side of the fatal range.[9] He considered the ratio of drug to metabolite meant he could conclude Mrs Howman was not using Fentanyl very regularly, and therefore would be naïve to the drug and possibly more susceptible to the potent respiratory depressed effect.[10]

He was also able to consider the ratio of the drug Fentanyl and its major metabolite, norfentanyl. After death he expected the drug and the metabolite would be at about the same level. In this case the active drug was nine times the level of the metabolite indicating use was very recent. He also noted that had Mrs Howman been using the drug Fentanyl for a number of days then the level of the metabolite norfentanyl would have been higher given the one to six hour half-life of the drug. This is the period of time required for the drug level to halve.

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[5] T2-29, L38
[6] T 2 p 27 43-47, p28, L1-3
[7] T2-30, L 23-29
[8] T2-33 L11-12
[9] T2-34, L 8-17
[10] T2-38,

Events following initial overdose of Fentanyl in 2010

Katie Howman's death was an unexpected tragedy for her family and friends, but not without portent. On 13 January 2010, Katie was fortunate to survive an intra-venous self-administered amount of Fentanyl she injected whilst at work at the Toowoomba Base Hospital. This occurred on her first day back at work after maternity leave. She was working in the critical care ward and went absent from the ward. She was discovered unconscious in the toilet and resuscitated. Her husband was informed by the hospital that Katie was in intensive care after injecting herself with a painkiller obtained at work. She subsequently acknowledged she had taken an amount of unused Fentanyl from a patient's syringe driver, replacing the quantity with similarly clear saline.

Heath Howman described his wife as a wonderful person, always helping others more than herself and a great mother of their two children. She also loved her work as a nurse. He was aware she had some significant and chronic health problems including depression and anxiety. Her husband was not unsympathetic; it was simply that his own upbringing in South Africa and his personality made him a more stoic and perhaps more resilient person. He also considered his wife had a relatively low threshold for pain, including her experience of migraines. He knew she had long-term problems and pain with her hips, as well as pain associated with polycystic ovarian syndrome and migraine. He was unaware of any self-harming behaviour by Katie, in particular he knew nothing of an apparent history of scratching / stabbing herself. It was not until a few months prior to her death that Heath became aware she was taking strong analgesics.

This episode led to Katie's suspension as a nurse. She was away from work on sick leave for six months and was referred to a psychiatrist and a psychologist for treatment. When she was assessed as being fit to return to work there was a period of supervision and restrictions regarding access to certain drugs. She was required to comply with mandatory drug testing directed by the Australian Health Practitioner Regulation Authority (AHPRA).

Coronial investigation

It is against this background that a coronial investigation was commenced. The initial information noted her husband had become concerned about three to four months prior to her death when Katie's behaviour became erratic and her moods varied markedly and unexpectedly. He reviewed bank records and discovered Katie was visiting a number of doctors in the Toowoomba area to source prescriptions for strong pain medication. When challenged by her husband she acknowledged to Heath that she might have a problem.

The investigation therefore included a review of Katie's access to prescription medication and attendance upon doctors.[11] Fentanyl had never been prescribed for her but, in the period between the first known overdose of Fentanyl in January 2010 and the second overdose of Fentanyl which was fatal, she had visited thirty different doctors in the Toowoomba area. Numerous prescriptions had been issued for strong

[11] Medicare Records- not for public access

opioid pain relieving medication, notably, tramadol and oxycodone. In particular, it was discovered she had visited twenty different doctors and fifteen different pharmacies in the thirteen months between 4 October 2012 and 22 November 2013. It was during these visits that she obtained 71 prescriptions providing her with 1,705 doses of oxycodone. In those last three months she had also obtained prescriptions for 340 doses of tramadol.[12]

While the cause of Katie's death due to Fentanyl toxicity was clearly established by autopsy findings, there remained factual issues to be resolved in establishing the circumstances and background leading to her death which required an inquest.

Consideration of public safety issues as well as how to prevent similar deaths occurring in the future also needed to be addressed.

Issues to be addressed at inquest

- Whether the processes for dispensing and disposing of Schedule 8 drugs, including Fentanyl, were appropriate at Toowoomba Hospital at the time of Mrs Howman's death

- Whether there were opportunities for Mrs Howman to obtain Fentanyl directly from patients under her care, after the drugs had been properly dispensed

- Whether Mrs Howman was properly supervised, and whether the process of supervision was sufficient

- Why the process of drug testing was unable to detect that Mrs Howman was systematically abusing opiates

- Whether Mrs Howman's history of NHS prescriptions was ever monitored during her professional supervision, and if not why not

- Whether it is easy or difficult for nursing and other medical staff, who may be addicted to some form of drugs, to obtain syringes and needles from their workplace

- Whether the final, fatal injection of Fentanyl was suicidal or inadvertent.

Undetected use of prescribed opioids

In the course of the coronial investigation the extraordinary extent of Katie Howman's doctor shopping within the Toowoomba area and the number of prescriptions she obtained for analgesics and opioids was revealed. Her longstanding and well respected general practitioner, Dr Leslie Dhaniram never suspected that he was not her primary medical advisor or that she was attending upon numerous other doctors. His records confirm Mrs Howman had a range of conditions causing her pain as well as mental health problems. He arranged for investigations and referred her on to

[12] See Annexure A with summary de-identified tables

appropriate specialists including orthopaedic, gynaecological, neurological, rheumatology, psychiatric and psychological specialties.

Dr Dhaniram prescribed Tramadol for pain relief. In more recent times the specialist psychiatrist, Dr Phillipson confirmed that Tramadol had been revealed as a potentially addictive synthetic opioid, but in earlier times, it was seen as a more benign medication less likely to be the cause of a patient developing dependency. Certainly Dr Dhaniram's prescribing of pain relief was modest and appropriate. No criticism could be made of his care. By September 2013, there was a revelation to Mrs Howman's treating psychologist of self-harming behaviour over years manifested in what was variously described as scratching/poking/stabbing herself with an injection needle. Dr Dhaniram saw this in the context of known mental health issues which were being treated.

Oxycodone was prescribed to Mrs Howman by Dr Dhaniram on one occasion only, on 5 November 2012.

Mrs Howman clearly concealed her increasing dependence on opioids from her primary treating general practitioner, and he had not suspected it. He was not alone in being deceived. It appears there was only one general practitioner of the thirty from whom she obtained prescriptions for oxycodone who felt it necessary to check with the Medicines Regulation and Quality unit within Queensland Health. This unit provides advice to doctors if they have detected a pattern of obtaining prescriptions which raises concern of dependency.

Psychiatric treatment

After Mrs Howman's first Fentanyl overdose in January 2010 she was resuscitated and transferred to Saint Andrews Private Hospital at Toowoomba. She was admitted under the care of consultant private psychiatrist, Dr Ross Phillipson who cared for Katie over the next 18 month period until June 2011.

Katie was adamant in her assertion to Dr Phillipson that the overdose was not an attempted suicide, but an impulsive action when she took the remainder of a patient's Fentanyl and injected herself. She denied illicit substance abuse. Dr Phillipson considered the action was a culmination of significant anxiety about her capacity to return to work in the critical care ward. This was despite initially returning as a 'supernumerary' working with another person, but with an expectation she would fairly quickly re-upskill in those areas that were required. He described her as tearful, co-operative and polite with apparent mood depression, and negative self-worth. There was no thought disorder or impairment. She was also embarrassed and ashamed and had difficulty believing she had done this. Dr Phillipson thought this was dissociative behaviour at the time, which is a symptom of high anxiety. It was the high anxiety together with the ready availability of the drug which gave her the opportunity to take the Fentanyl.

He diagnosed dysthymic disorder with recent increase in depression on a background of anxious temperament. He prescribed anti-depressant and anti-anxiety (anxiolytic) medication and referred her to a psychologist, Sharon Wilkinson.

There was nothing in the information available that implied Katie had ever behaved in this way before or had any problem of dependency.

He confirmed it likely that an illicit user of narcotic analgesics would experience a high, a feeling of relaxation or exuberance, which is the opposite of anxiety. Her use of tramadol was disclosed by Katie to Dr Phillipson and, at the time, was appropriately prescribed by a treating specialist for another condition.

It is noted that the escalating pattern of oxycodone use did not commence during the period of Dr Phillipson's psychiatric care.

He also noted tramadol was generally less likely to be an addictive analgesic, although he said years of experience now shows that there are some people who will become dependent on tramadol as well.

Dr Phillipson stated that routine drug testing does not include testing for oxycodone; it must be specifically requested to be included in the test.

He was aware that in June 2011 Katie suffered a seizure. This was thought to be caused by combination of anti-depressant medication and use of tramadol. She had withdrawn use of tramadol and then re-instated its use at the full level, rather than gradually titrating the dose.

Dr Phillipson confirmed it was always inappropriate to prescribe strong analgesics like oxycodone or tramadol to treat anxiety or depression. They are not designed for this purpose and have a high risk of dependency.

Dr Phillipson knew Katie was under the supervision of AHPRA which required her to abstain from any codeine containing preparation. Katie denied breaching this restriction. Indeed he did not suspect she was abusing any medication. She always presented well and there were no observable signs. He considered rapport had been established in the doctor patient interaction, but only realised in retrospect that this had not been sufficient for Katie to make full disclosure[13].

He acknowledged he had received a copy of the report of the psychiatrist, Dr Storor, requested by AHPRA. Dr Storor's assessment in February 2010 had focused on the abuse of Fentanyl, reaching a conclusion she was dependent after this one known episode of Fentanyl administration.

Nor had Katie disclosed to her psychiatrist that she had a history of self-harming by using a sterile injection needle to stab herself. It was only after her death that Dr Phillipson became aware from information revealed to the psychologist Dr Wilkinson some few months prior to her death. This was after Dr Phillipson had retired and handed her treatment on to her longstanding general practitioner, having first assessed her as sufficiently well for this to be appropriate. He confirmed there is usually a flow of communication between psychiatrist and psychologist regarding a patient being treated.

[13] T2-60 lines 20-22

Had he been aware of this self-harming behaviour it would have alerted him and he would have had greater concern that she had been struggling with anxiety for a longer time and may also have other personality difficulties.

By July 2010, Dr Phillipson supported the graduated return to her nursing work at the critical care ward and considered it would potentially be therapeutic and beneficial to her, particularly noting the supportive work environment provided by her employer, the Toowoomba Base Hospital.

She was to be supervised by a senior nurse and not to have access to S8 class drugs or key access for 12 months. Nor would she be able to administer these class of drugs to patients. Psychiatric and psychologist's care was to continue and she must submit to regular urine drug screening tests.

By this date he considered group 4 screening was sufficient as there was no information of any other drug abuse. Only tramadol had shown up in screening and this had been prescribed for her hip pain. It was on 23 September 2010 that Katie returned to work.

She continued to improve and in January 2011 requested two night shifts per week, but this was declined by the hospital. Dr Phillipson agreed to reduce the drug screening to group 5 as there was no information to counter this and Katie continued to improve. By May she was performing the night shift, which unsurprisingly was exhausting. She also had some problems with sleep due to hip pain but was expressing a plan to reduce tramadol despite this.

At her final appointment with Dr Phillipson in June 2011 he cautioned Katie to continue taking the prescribed anti-depressant and contact her general practitioner if her mood declined.

Dr Phillipson was surprised and saddened by the news of Katie's death in December 2013. He found it difficult to believe she had intended her death, particularly noting she had a second child since he had last seen her. He was however surprised to learn of the psychologist's report which included information that Katie had used a syringe in a controlled self-harm manner which she had concealed from her husband. This led Dr Phillipson to wonder what else she might have withheld in the course of her treatment by him. He had not suspected her of deceiving him. She had concealed her opioid use from him. (It must be noted that it was not until October 2012 that Katie was prescribed oxycodone.)

Challenges of treating health professionals

Dr Phillipson noted there were difficulties in assisting health professionals who failed to disclose problems of addiction because often they did not give any outward sign of a problem. With their access to general medical knowledge they were often able to explain themselves and lull their treating doctor into a false sense of security.

Dr Phillipson highlighted another possible reason for deception was the tension created in the requirement for a treating doctor to provide clinical reports to AHPRA or other regulatory authorities. A health professional would be aware of this requirement and, in Dr Phillipson's view it was probably a factor in Katie failing to make full

disclosure of the full extent of her illness and difficulties, knowing this information could be accessed by APHRA and the Nursing Board. Dr Phillipson stated-

"Under the AHPRA guidelines impairment implies that there is likely to be significant difficulties with interaction with the public or a patient."[14]

He went on to say-

There are a lot of people out there- nurses, doctors, whoever who have illnesses which don't come close to the definition of impairment but, my feeling is that a lot of our colleagues are worried that if they say they have depression, anxiety, whatever, that they're going to be reported to AHPRA and I think that acts as a block in terms of full disclosure.[15]

Ideally Dr Phillipson proposed a treating practitioner would alert AHPRA if there was a problem concerning a patient, but the details of the problem would not necessarily be released to AHPRA. He would expect AHPRA would want to know;

(i) that the person was being treated
(ii) was compliant with treatment
(iii) when it is possible the person might be able to gradually return to work given their condition.

He understood this was the situation in Western Australia.

Although Dr Phillipson considered there had been an improvement with the changed requirement to report to the Office of Health Ombudsman in circumstances of a *substantial risk of harm to the public*, he still considered there was a difficulty when treating patients who were health professionals. Their natural inclination remained to believe that everything they disclosed would be reported to the regulatory authority. Dr Phillipson considered expanding and continuing education around this issue would assist. This could be undertaken by AHPRA, (and by the Office of Health Ombudsman), by the College of Psychiatrists and the College of General Practitioners.

Dr Phillipson was not convinced AHPRA needed to know all the details of a person's psychiatric condition and how it was impacting on family and other things. [16] He acknowledged it was a terrible dilemma with no easy answers.

AHPRAS' role

- Why the process of drug testing was unable to detect that Mrs Howman was systematically abusing opiates
- Whether Mrs Howman's history of NHS prescriptions was ever monitored during her professional supervision, and if not why not.

The regulatory authority AHPRA's primary focus in managing a health practitioner is to maintain the health and safety of the public rather than the health practitioner. In doing this AHPRA must use minimum regulatory force to manage the risk posed by a

[14] T 2-55 line 13
[15] T2-55 line lines 15-19
[16] T2-64ines 2-4

health practitioner. It is acknowledged by AHPRA that practitioners will sometimes feel that AHPRA's actions are punitive.

The main issue in the facts relating to Katie Howman and her supervision by AHPRA was the failure to detect Katie had a broad opiate dependency problem which developed over the period of supervision. The advice provided to AHPRA by their specialist psychiatrist, Dr Storor, was that Katie Howman was addicted to Fentanyl, (an opiate.) Although this conclusion might have been somewhat surprising at the time given the information was of a one off known use of self-administered intravenous Fentanyl, subsequent events proved Dr Storor correct. It was however the advice that AHPRA received at the time. So, although it might not have been the required Australian Standards testing protocol to include oxycodone testing in its regime of drug screening, it is somewhat surprising that broader opiate screening was not considered from the outset. She was never prescribed Fentanyl, but she worked in a critical care ward where there was opportunity, despite safeguards, that she might access opioids.

It is noted that subsequent evidence based advice from Professor Olaf Drummer recommends greater testing in similar circumstances, including for oxycodone. This has been adopted. AHPRA has also acknowledged the value of real time information regarding prescription shopping and access to information about the number of medical practitioners being attended.

Hospital's role

Dr Peter Gillies gave evidence on behalf of the Toowoomba Base Hospital. He had worked at the hospital since 2009 in varying positions including as Deputy Director of Medical Services, Director of Medical Services and Executive Director of Medical Services. Since 2014 and at the time of inquest he was the General Manager of the hospital overseeing clinical services and operational governance. He confirmed Mrs Howman was a registered nurse working at the hospital from 2004. She qualified to work in the Critical Care Ward and commenced a permanent position in that ward in February 2009.

- Whether the processes for dispensing and disposing of Schedule 8 drugs, including Fentanyl, were appropriate at Toowoomba Hospital at the time of Mrs Howman's death
- Whether there were opportunities for Mrs Howman to obtain Fentanyl directly from patients under her care, after the drugs had been properly dispensed
- Whether Mrs Howman was properly supervised, and whether the process of supervision was sufficient.

These three issues are dealt with together.

The Toowoomba Base Hospital used the appropriate comprehensive and prescriptive Darling Downs Hospital & Health Service Medication Manual. [17] This document identified this category of drugs and listed the required storage, supply, transport, documentation, administration and disposal of the drug, which included Fentanyl. There was also a process for mandatory checks and audits, including random audits

[17] Exhibit C7.3

and recording and immediate notification of discrepancies. The management of these drugs within operating theatres was addressed as well as patients' own supply of drugs, including potentially illicit drugs. There were requirements for storage of this category of drug in units that did not operate 24 hours, or upon temporary closure of a ward or return of the drugs to the pharmacy.

The problem of course is not the lack of a policy but how that policy is complied with and how non-compliance is identified and dealt with.

It is beyond dispute that despite a policy that required the presence of two authorised persons to be present when the drug is administered or disposed of, Katie Howman managed to access Fentanyl in January 2010. This was in an open critical care unit. She withdrew the unused portion of a premixed Fentanyl / saline solution from an infusion which was not running at the time to a ventilated patient. She made up the volume with saline and left the ward. On her own admission she administered the Fentanyl to herself intravenously, not in a controlled manner as would have occurred via a syringe driver, but in such a manner that she was lucky to be found alive, but unconscious by staff who noticed her absence. This absence from the ward was for a noticeably long time.

There is no direct evidence of the source of the Fentanyl which was identified in Katie Howman' body the day she died on 21 December 2013.

What is known is;

- There is no record of prescription of the medication Fentanyl to Katie Howman at any time,
- She was at work in the critical care ward on the day preceding her death, the environment where she had once previously illicitly accessed Fentanyl.
- She died on the first day of her scheduled holiday leave after self-administration of intravenous Fentanyl.
- There had been an escalating number of documented incidents or issues of concern relating to Katie Howman in her workplace after her return to work, increasing in the period immediately leading up to her death.

The first documented concern expressed by another staff member was in August 2011 and directed to the then Nurse Unit Manager. New medication (to control seizures) was making her unwell, she felt unsupported at home and there was concern with long bathroom breaks. Concern was expressed for patient safety, for Katie and for the integrity of the unit. This was in turn passed on to APHRA in September 2011.

An incident on 18 September 2011 is particularly significant. Another nurse had failed to properly dispose of a controlled S8 drug (morphine in a syringe) which had been left in a patient's bedside drawer. That nurse returned to dispose of it and found it gone- at which point Katie Howman volunteered that she had disposed of the syringe in the sharps container assuming it was saline. This incident demonstrates that whatever the policy, there were occasions when practice did not meet the required standard, and, on this occasion it was Katie Howman who last handled a quantity of morphine in a syringe. It cannot of course be established whether this was innocent or not, given her response she thought it was saline.

Katie was then on maternity leave from May 2012 until April 2013.

After her return, a serious incident occurred on 22 August 2013. Katie was seen to have exited from the toilet and immediately discarded a paper bag in the sharps bin. When retrieved there was a 20ml BD syringe, with a few droplets of clear liquid and a 21 gauge needle, not attached. When confronted Katie claimed her action was a form of self-harm using a needle to pierce the skin but not to inject herself. The hospital reported this to AHPRA who could not disclose the nature of Katie's medical issue. Attempts were made to identify the contents of the syringe but were unable to be pursued.

Further communication occurred between APHRA and the hospital and a detailed management plan was prepared. This excluded her from night shifts and required continuing visits to her psychologist. By this time AHPRA had decided to formally investigate her and assess whether she was 'impaired' with respect to her capacity to work safely.

It was then in September 2013 that the staff member who first raised concern regarding Katie in August 2010, again contacted senior nursing staff. By this time the complaint had escalated. There was concern about Katie's erratic behaviour, poor patient management and long absences. This was causing stress and frustration with other co-workers and medical staff and a risk to patients. The previously supportive co -worker was now calling for Katie to be removed from the workplace.

This then led to further restrictions on Katie's nursing practice which was now restricted to 8 hours shifts. It was on 1 November 2013 that APHRA notified the hospital that APHRA would investigate Katie for a health impairment relating to drug misuse, abuse or addiction. APHPRA then required further information of the hospital.

On 19 November 2013, there was complaint about her failure to record patient observations. On 2 November cafeteria staff and hospital security staff observed her behaviour in the hospital but not on the ward which caused them concern and prompted report to management. On 27 November staff reported bizarre behaviour and on 2 December odd behaviour was observed followed by discovery of a syringe in a bathroom.

By 5 December APHRA had appointed a senior nurse unit manager to formally supervise conditions imposed by the board – but still without disclosing the nature of the health matter. She could only practice under supervision. Weekly meetings were held with Katie to ensure fitness and competence to continue working.

The hospital was supportive of Katie throughout these events while not compromising public health and safety. They have appropriately recognised that while proper policies for safe access, administration and disposal of controlled drugs and S8 drugs are in place, there can never be room for complacency. Vigilance and leadership backed up with rigid adherence to protocols must be maintained, audited and enforced. A low threshold of suspicion should apply. The disposal of unused portions of drugs appears to be the area in which there is the greatest opportunity for inappropriate access and must be guarded against. Sadly, there have been a number of theatre technicians, nurses and anaesthetists over the years who have died after accessing restricted

medication. In this coroners' experience, none appeared to have an intention to die and all were overconfident of their capacity to control their own need.

After Katie's death the hospital convened a meeting for staff who had worked as part of the critical care ward during the same period with Katie Howman. The meeting [18] was only convened after prompting from a previous Clinical Director of the hospital who had worked in the unit and knew many staff members. He had been approached by a staff member who was very upset. He was not alone in his distress. The crux of the anger and distress from other staff members was the very natural reaction of grief at the death of a colleague and their frustration at unanswered questions about Katie's management throughout the period. The hospital of course was in a difficult position due to constraints of privacy and their dual role of protecting public safety but also the welfare (and privacy) of an employee.

A debriefing occurred and was followed up with counselling for those staff members who wished to avail themselves of the support.

Having considered the emotional damage to colleagues and the potential damage to professional reputations from this sequence of events, (and following other deaths of health practitioners) a recommendation will be made to suggest better communication and support within a work environment where a staff member is being managed with respect to their health, which could include possible dependency / addiction.

Conclusion

Katie Howman died at her home at 9 Kestrel Court Toowoomba in Queensland on 21 December 2013. She died due to a Fentanyl overdose caused by self-administration of intravenous Fentanyl. The drug was most likely misappropriated from her workplace in the Critical Care Ward at the Toowoomba Base Hospital where she worked as a registered nurse.

After her death a review of autopsy findings together with Medicare records confirmed the tragic fact that she was opioid dependent on prescribed medication. Her dependency had developed over time. Initially she had been appropriately prescribed opioid analgesics for various medical conditions causing her pain. The findings by the forensic pathologist of giant cell granulomas adjacent to blood vessels throughout the lungs was consistent with intravenous drug abuse. These characteristics only develop over time by a long process of repeated use causing the body to develop this response.

Although it was an overdose of Fentanyl that caused her death, the evidence of longstanding intravenous drug use in the lungs was more likely associated with repeated administration of oxycodone and tramadol. The records from Medicare detailed the history of obtaining excessive quantities particularly of oxycodone from numerous doctors, and this escalated to the time of her death.

[18] On 6 March 2014

The pathologist who performed the autopsy concluded Katie was an intravenous drug abuser. This was consistent with the evidence of doctor shopping behaviour to source opioids.

There had been serious efforts by her employer to prevent a repetition of the first known misappropriation of Fentanyl in the workplace, which had occurred in January 2010.

She was suspended from her practice as a nurse by AHPRA in its capacity as the Nursing and Midwifery Board. Conditions and restrictions were imposed on her return to practice, including prohibition from handling or administering S8 controlled drugs which included the opioid, Fentanyl.

This was entirely appropriate in all the circumstances. She was required to attend upon a psychiatrist and psychologist for treatment. She was diagnosed as suffering severe depression and anxiety. It was against this background that events unfolded leading to her death. Her drug seeking behaviour developed, most probably seeking to alleviate her pain, anxiety and distress. She was required to provide urine samples for drug testing over an extended period of time. The drug testing continued after her authorised return to work at the hospital and there were varying restrictions on her practice. At no time did she return a specimen that revealed a drug that could not be accounted for by a medical prescription.[19]

But despite these appropriate and necessary controls and the conscientious and supportive supervision by her employer, who also bore responsibility with APHRA to ensure public safety, Katie died due to an opioid overdose.

There is no evidence that her death was a suicide and it is concluded to be an inadvertent accidental overdose of medication that had not been prescribed for her.

How this could have occurred is partially explicable due to the sad reality that this young woman, who was a loved wife and mother and a previously well regarded and valued member of nursing staff, was also capable of successful deception on numerous occasions. It was not until the last few months of her life that her husband became suspicious of her fluctuating moods and behaviours and pressured her into a partial admission that she ‘might have a problem’.

With hindsight there was an early incident that now appears to be more suspicious than when it was interpreted in September 2011. Katie Howman claimed she disposed of a syringe of unused morphine in the sharps receptacle after another nurse failed to properly dispose of this or document the disposal. Katie Howman’s explanation that she had thought it to be simple saline solution was accepted at the time.

But it was the period of time from August 2013 until her death that was of most concern. There were escalating complaints of erratic behaviour, absences from the ward, and suspicions that she had injected herself with a syringe. Although the hospital responded to staff concerns and reported the matters to AHPRA, the course of events continued. By the end of November 2013 there was even a report from ancillary staff

[19] 54 of 63 urine drug tests were positive for tramadol, which was prescribed. Exhibit F2 para 37

in another area of the hospital. They were concerned about her bizarre behaviour. The particulars included physical observations raising suspicions of drug use.

The critical issue is that neither the hospital nor AHPRA had any evidence to confirm their suspicions. AHPRA could have made application to review the prescription history and record of attendances upon doctors, but they did not do so. They indicated some resistance to the release of such information by Medicare at that time.

Recommendation 1

If there is in fact an impediment to release of such information to AHPRA, it is recommended this issue should be urgently investigated, reviewed and legislatively changed if required. AHPRA should then regularly monitor the PBS records, especially where a condition has been imposed to attend upon only one doctor or not to obtain prescriptions for a particular medication.

The tragedy is that there was an undeniable record of Katie's growing dependency and reckless behaviour in accessing prescriptions for opioids. She was doctor shopping within the wider Toowoomba area and beyond, sourcing oxycodone as well as tramadol. She attended as many as 30 different doctors from March 2010 and numerous different pharmacies. The record shows she would attend upon a doctor on a number of occasions before moving on to another doctor. The information was recorded by Medicare and accessible by any doctor who had treated her. Only one doctor formed a suspicion prompting enquiry and discovered the Qld Drugs of Dependency Unit had flagged the patient. That doctor commenced trying to wean Katie from the drug, but the record shows her patient continued to visit other doctors to source oxycodone.

The Commonwealth Prescription Shopping Information Service provides an 1800 telephone number [20] which can identify in any given three month period;

a) if a patient has consulted six or more doctors for pharmaceutical benefits scheme (PBS) prescriptions, or
b) if a patient has obtained 25 or more PBS prescriptions for controlled drugs or drugs of dependence , or
c) if a patient has obtained 50 or more general PBS prescriptions.

The information is said to be relatively up to date, within about a couple of weeks.

In Queensland, the Queensland Health Drugs of Dependency Unit Enquiry Service[21], (now named Medicines Regulation and Quality Unit) provides information to doctors about a patient who has consulted them regarding :

- prescribing history for controlled drugs
- information about whether the patient is consulting other doctors
- whether the patient is on an opioid treatment plan
- their drug dependence status

[20] 1800631181 or 33289890
[21] 0733289890

- if other general practitioners have raised questions about the same patient.

The unit can also provide clinical patient management advice.

The deficiency in the existing information systems is that they are reliant on a doctor or pharmacist forming a suspicion prompting a request for information, and, the information is not available in real time.

There are other Australian jurisdictions currently using real time information software retrieval systems to inform decision making.[22] There is undoubtedly a huge human and fiscal cost in the way the Pharmaceutical Benefits Scheme is currently being misused to source and subsidise controlled drugs and drugs of dependence. There have been many previous inquests throughout Australia that have highlighted deaths due to overdose, usually inadvertent, of people who have developed a dependency on prescribed medication. Countless more deaths have been reported to coroners where findings have been made without a public inquest.[23] And there have been repeated previous recommendations made by coroners to improve the real time accessibility of information for doctors and pharmacists about their patient's prescription history.

Recommendation 2

It is strongly recommended that there be statutory change to enable real time access to relevant prescription and doctor attendance history. It is noted the New Zealand model forwards information of concern out to the treating doctor rather than relying on the doctor contacting the information service. No doubt there would be ways to accommodate privacy issues while still safeguarding patients from harm and the abuse of a publically funded resource. These matters should be urgently investigated and considered by government.

It is also noted that in this matter AHPRA did not direct routine testing of a broad range of opioids following the initial report of misuse of Fentanyl. In particular, no testing of urine samples for oxycodone was performed despite this being a notoriously frequently abused opioid drug.

The inquest was assured that a comprehensive review by Professor Olaf Drummer has led to evidence based advice on best practice screening procedures. The inquest was assured that should a similar incident occur, AHPRA would now routinely order broad screening for opioids. This improvement is commended.

Recommendation 3

It is recommended that AHPRA should also routinely seek doctor attendance and prescription history of health practitioners under supervision. If there are legislative restrictions impeding their ease of timely access to information, these should be reviewed.

[22] Tasmania and Northern Territory

[23] Recommendations of Deputy State Coroner Forbes, NSW re deaths of Christopher Salib, Nathan Attard and Shamsad Akhtar

How best to manage the challenge of a health professional who has become drug dependent remains a vexed issue. Katie Howman's very experienced treating psychiatrist Dr Ross Phillipson was thoughtful, considered and persuasive in providing evidence and professional opinion at the inquest. He was no longer treating Mrs Howman after June 2011 and was unaware of his patient's subsequent development of oxycodone dependency. Dr Phillipson noted one of the underlying problems with treating health professionals with an addiction was the tension created for the doctor who was required to provide clinical reports to AHPRA or other regulatory authorities. The health professional being treated is no doubt aware of the requirement and might be less likely to disclose full and frank information.

Recommendation 4

It is recommended that Dr Phillipson's advice be considered. He suggested a more limited requirement to report to AHPRA would meet both the public safety requirement for AHPRA while providing the most therapeutic environment for the health practitioner to receive treatment. He suggested a treating doctor report to AHPRA the following;

(i) that the person was being treated,
(ii) was compliant with treatment and
(iii)when it is possible the person might be able to gradually return to work given their condition.

He also recommended expanding and continuing education around the issue by AHPRA, the Office of the Health Ombudsman and by the College of Psychiatrists and the College of General Practitioners.

AHPRA's primary responsibility in the circumstances of a drug dependent health practitioner must be the safety of the public, but, there is the possibility of the regulator being more effective in the role if they were seen to be also more supportive of rehabilitation of the health practitioner.

Recommendation 5

It is recommended that AHPRA consider whether there is scope within their role to also adopt and provide a more rehabilitative capability, such as the Nursing and Midwifery Health Program in Victoria. Alternatively such resourcing could be considered by government to directly fund a service which solely provides rehabilitation service and is exempted from any requirement to report to AHPRA while a practitioner is receiving treatment.

Recommendation 6

Access to Medicare rebates for drug testing ordered by AHPRA should logically also be considered.

Having considered the emotional damage to colleagues and the potential damage to professional reputations from this sequence of events, (and following other deaths of health practitioners) a recommendation will be made to suggest better communication and support within a work environment where a staff member is being managed with respect to their health, which could include possible dependency/addiction.

Recommendation 7

It is recommended that hospitals managing a health practitioner in the workplace who is subject to AHPRA supervision consider the lessons learned from the experience of the Toowoomba Hospital. In the aftermath of their co-worker's death, staff agreed for the future to notify managers/team leaders verbally or in writing if they were concerned regarding the behaviours of a co-worker in a work unit. If a staff member was maintained in a work unit with restrictions placed on their practice, the staff member would have to agree to disclosing restrictions to other staff members working with them as part of the agreement. It is suggested that Qld Health consider this kind of agreement in the context of caring for co-worker's emotional wellbeing and professional reputations as well as those of the practitioner under management.

I thank all those who have assisted in the inquest into the death of Katie Howman. It is hoped that the painful review of her tragic death will lead to changes making it less likely that another young family experiences such grief.

I close the inquest.

Christine Clements
Brisbane Coroner
Brisbane
27 July 2015

ANNEXURE A

DE-IDENTIFIED SUMMARY TABLES RECORDING MONTHLY ATTENDANCES ON DOCTORS AND PRESRIPTIONS OF OXYCODONE

OCTOBER 2012

Prescription date	Supply	Medication	Quantity	Doctor	Pharmacy
4/10/12	4/10/12	Oxycodone hydrochloride	20	"A"	1
4/10/12	5/10/12	Oxycodone hydrochloride	20	"A"	2
8/10/12	8/10/12	Oxycodone hydrochloride	28	"B"	3
11/10/12	11/10/12	Oxycodone hydrochloride	20	"B"	3
11/10/12	11/10/12	Oxycodone hydrochloride	28	"B"	3
15/10/12	16/10/12	Oxycodone hydrochloride	20	"B"	4
15/10/12	16/10/12	Oxycodone hydrochloride	28	"B"	4
19/10/12	19/10/12	Oxycodone hydrochloride	20	"C"	5
19/10/12	19/10/12	Oxycodone hydrochloride	56	"C"	5
25/10/12	25/10/12	Oxycodone hydrochloride	20	"D"	6
25/10/12	15/10/12	Oxycodone hydrochloride	28	"D"	6
30/10/12	30/10/12	Oxycodone hydrochloride	20	"E"	3
30/10/12	30/10/12	Oxycodone hydrochloride	28	"E"	3
			Total for October 336 tablets	**5 doctors**	**6 pharmacies visited in 1 month**

NOVEMBER 2012

Prescription date	Supply Date	Medication	Quantity	Doctor	Pharmacy
1/11/12	1/11/12	Oxycodone hydrochloride	20	"B"	5
1/11/12	1/11/12	Oxycodone hydrochloride	28	"B"	5
5/11/12	5/11/12	Oxycodone hydrochloride	20	"F"	3
7/11/12	7/11/12	Oxycodone hydrochloride	20	"G"	7
7/11/12	7/11/12	Oxycodone hydrochloride	28	"G"	7
30/11/12	30/11/12	Oxycodone hydrochloride	20	"H"	7
			Total for November 136 tablets	**8 different doctors in 2 months**	**7 different pharmacies in 2 months**

DECEMBER 2012

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
3/12/12	3/12/12	Oxycodone	28	"G"	3
5/12/12	5/12/12	Oxycodone	28	"G"	3
13/12/12	13/12/12	Oxycodone	20	"I"	8
13/12/12	13/12/12	Oxycodone	20	"I"	8
13/12/12	13/12/13	Oxycodone	10	"I"	8
17/12/12	21/12/12	Oxycodone	20	"J"	1
17/12/12	17/12/12	Oxycodone	28	"J"	6
17/12/12	11/01/13	Oxycodone	60	"J"	19
17/12/12	17/12/12	Oxycodone	28	"J"	6

20/12/12	20/12/12	Oxycodone	28	“B”	3
24/12/12	24/12/12	Oxycodone	20	“B”	3
24/12/12	24/12/12	Oxycodone	28	“B”	3
27/12/12	27/12/12	Oxycodone	20	“K”	6
27/12/12	27/12/12	Oxycodone	28	“K”	6
			Total for December 366 tablets	**11 different doctors in 3 months**	**9 pharmacies in 3 months**

FEBRUARY 2013 – NB no doctor or pharmacy visits during January 2013

Prescription date	**Supply date**	**Medication**	**Quantity**	**Doctor**	**Pharmacy**
7/2/13	7/2/13	Oxycodone	20	“L”	3
12/2/13	12/2/13	Oxycodone	20	“L”	3
20/2/13	20/2/13	Oxycodone	20	“H”	3
22/2/13	22/2/13	Oxycodone	28	“A”	10
			Total for February 2013 88 tablets	**12 different doctors in 5 months**	**10 different pharmacies in 5 months**

MARCH 2013

Prescription date	**Supply date**	**Medication**	**Quantity**	**Doctor**	**Pharmacy**
4/3/13	4/3/13	Oxycodone	20	“I”	8
7/3/13	7/3/13	Oxycodone	28	“L”	3
11/3/13	11/3/13	Oxycodone	14	“L”	3
19/3/13	19/3/13	Oxycodone	14	“L”	3
25/3/13	25/3/13	Oxycodone	7	“L”	3
25/3/13	25/3/13	Oxycodone	14	“L”	3

			Total for March 2013 97	**12 different doctors in 6 months**	**10 different pharmacies in 6 months**

APRIL 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
2/4/13	2/4/13	Oxycodone	14	“L”	3
12/4/13	12/4/13	Oxycodone	14	“L”	3
17/4/13	17/4/13	Oxycodone	28	“M”	3
			Total for April 2013 56	**13 different doctors in 7 months**	**10 different pharmacies in 7 months**

MAY 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
1/5/13	1/5/13	Oxycodone	10	“M”	3
8/5/13	8/5/13	Oxycodone	20	“N”	10
8/5/13	8/5/13	Oxycodone	28	“N”	10
16/5/13	16/5/13	Oxycodone	20	“C”	3
16/5/13	16/5/13	Oxycodone	28	“C”	3
21/5/13	21/5/13	Oxycodone	20	“C”	12
21/5/13	21/5/13	Oxycodone	28	“C”	12
			Total for May 2013 154	**14 different doctors in 8 months**	**12 different pharmacies in 8 months**

JUNE 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
5/6/13	5/6/13	Oxycodone	28	“E”	3
14/6/13	14/6/13	Oxycodone	20	“G”	3

18/6/13	18/6/13	Oxycodone	20	“O”	9
18/6/13	18/6/13	Oxycodone	28	“O”	9
20/6/13	20/6/13	Oxycodone	28	“C”	3
26/6/13	26/6/13	Oxycodone	28	“G”	7
			Total for June 2013 152 tablets	**15 different doctors in 9 months**	**12 different pharmacies in 9 months**

JULY 2013

Prescription date	**Supply date**	**Medication**	**Quantity**	**Doctor**	**Pharmacy**
2/7/13	2/7/13	Oxycodone	28	“O”	9
15/7/13	15/7/13	Oxycodone	28	“C”	3
18/7/13	18/7/13	Oxycodone	28	“C”	12
24/7/13	24/7/13	Oxycodone	28	“P”	13
			Total for July 2013 112	**16 different doctors in 9 months**	**13 different pharmacies in 9 months**

AUGUST 2013

Prescription date	**Supply date**	**Medication**	**Quantity**	**Doctor**	**Pharmacy**
2/8/13	2/8/13	Oxycodone	20	“P”	13
15/8/13	15/8/13	Oxycodone	28	“P”	12
19/8/13	19/8/13	Oxycodone	28	“Q”	13
			Total for August 2013 76	**17 different doctors in 9 months**	**13 different pharmacies in 9 months**

SEPTEMBER 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
10/9/13	10/9/13	Oxycodone	28	"P"	13
10/9/13	10/9/13	Oxycodone	28	"P"	14
****Note 120 Tramadol also supplied this month**			**Total September 2013 56**	**17 different doctors in 11 months**	**14 different pharmacies in 11 months**

OCOTBER 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
11/10/13	11/10/13	Oxycodone	28	"R"	13
11/10/13	11/10/13	Oxycodone	28	"R"	13
****Note 120 Tramadol also supplied this month**			**Total for October 56**	**18 different doctors in 12 months**	**13 different pharmacies in 12 months**

NOVEMBER 2013

Prescription date	Supply date	Medication	Quantity	Doctor	Pharmacy
22/11/13	22/11/13	Oxycodone	20	"S"	15
****Note 100 tramadol also supplied this month**			**Total for November 2013 20**	**20 different doctors in 13 months**	**15 different pharmacies in 13 months**