QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of LAMH**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Southport
DATE:	30 November 2016
FILE NO(s):	2011/3029
FINDINGS OF:	James McDougall, Coroner
CATCHWORDS:	CORONERS: Opioid Treatment Program, medication and illicit drugs, domestic violence, conduct of general practitioner, AHPRA investigations
Counsel Assisting:	Rhiannon Helsen

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Background

LAMH (Ms H) was 31 years of age at the time of her death. She resided with her partner, AO'S at Old Cleveland Road East, Birkdale. They had commenced living together in March 2011. The residence was owned by AO'S's father. Their relationship was reportedly volatile and violent.

Ms H had a long-standing history of illicit drug use, which included heroin and amphetamines. Between 2008 and 2010, she had participated in the Queensland Opioid Treatment Program (QOTP), which provides methadone or buprenorphine for patients who are diagnosed with opioid dependence, particularly if they are injecting medication and/or illicit drugs.

AO'S was well known to police, having a notable criminal history. He was also previously a person of interest in relation to two unrelated deaths, the circumstances of which are not relevant for the purpose of this coronial investigation.

Sequence of events

At 7.57am on 1 September 2011, an anonymous male caller contacted triple 0 to report that a female had been found lying on the floor at Ms H's residence and an ambulance was required. The male declined to provide his particulars before hanging up.

Queensland Ambulance Service (QAS) officers subsequently attended the address and received no response from inside the residence. A visual inspection of the two storey dwelling was conducted, during which a female was observed through the downstairs window, lying on the floor in the dining room area. Entry was gained through a closed but unlocked front door. An examination of the female found her to be unresponsive and showing no signs of life. She was lying on her side next to the dining room table. There was a towel under her head and a blanket which had been tucked around her in a manner that seemed to be comforting. A visual inspection of the female did not reveal any signs of trauma and there was no indication that a disturbance had occurred in the dwelling. She was declared deceased at the scene.

Police were subsequently notified and attended the residence. Police were aware that AO'S possibly resided at the residence. A crime scene was established at the residence and also at a Telstra phone booth near the Manly Railway Station where the triple 0 call originated.

Through fingerprints, the deceased female was formerly identified as Ms H. At the time of her death, Ms H and AO'S were both on remand having recently been charged with drug trafficking. They were both known heroin and pharmaceutical drug users.

A visual and forensic inspection of the residence was conducted by police. On the table next to Ms H, a capped syringe, a box of five Fentanyl patches prescribed to her by Dr JS, and a spoon with melted plastic on it, were found. Lying on the floor next to Ms H was an uncapped syringe. Forensic testing confirmed the presence of Fentanyl in one of the syringes and spoon found at the scene.

Police subsequently conducted a door knock of the surrounding residences which revealed that there had been a verbal argument heard at the residence on 30 August 2011, however, no reports were made to police. It seemed that verbal arguments were a regular occurrence at the address. Police records confirm that there had been three previous instances of domestic violence between Ms H and AO'S.

CCTV footage from the Manly Railway Station prior to the triple 0 call being made clearly showed AO'S in the area.

On 31 August 2011, AO'S failed to attend an interview scheduled with the Brisbane City

Tactical Crime Squad officers in relation to an allegation that he was unlawfully in possession of the drug Xanax.

On 1 September 2011, officers spoke to Tanya Lacey of Lacey and Peters Lawyers, who confirmed she was acting for AO'S. She advised that AO'S's version of events was that Ms H had woken in the morning and heated the Fentanyl patch on a spoon before injecting the extracted opiate. She suffered a drug overdose and then died. AO'S panicked and left the residence, calling QAS from a phone box near the Manly Railway Station. She indicated that AO'S was too sick to speak to police at the time.

On 2 September 2011, AO'S was arrested in relation to an unrelated breach of bail. He formally refused to participate in an interview with police in relation to Ms H's death. He did, however, agree to provide a blood sample for the purpose of forensic testing. Tests confirmed that AO'S had a number of prescription medications in his blood including, clonazepam, Fentanyl and quetiapine.

Autopsy findings

On 2 September 2011, an external and full internal post-mortem examination was performed. A number of histology and toxicology tests were also performed.

Toxicology testing confirmed the presence of multiple drugs including amphetamine and methylamphetamine (0.02 mg/kg), as well as prescription drugs including, metabolite of diazepam, clonazepam and its metabolite, Fentanyl (0.019 mg/kg) and its metabolite, and salicylic acid. The concentration of Fentanyl detected in the blood was at a toxic level and would have caused death on its own. Toxicity in Fentanyl can result in severe respiratory depression, muscle rigidity, seizures, coma and hypotension.

The external examination revealed fresh and old needle track marks in the folds of the elbow and the front of the forearms indicative of recreational drug use. Minor bruising was also noted on the front of the knees, on the shins, neck and on the back of the forearms. Subcutaneous dissection of the facial skin revealed an extensive area of haemorrhage on the left cheek and left mandible. There was no fracture of the laryngeal skeleton and hyoid bone. These bruises were found to be equivocal and may have been caused in an intravenous drug user as a result of a fall or contact with objects, such as furniture, whilst drug affected. The bruising on the face would have been inflicted by a blunt object such as a fist or an open palm, or a fall onto a surface, such as the floor/ground with mild to moderate force. There was no significant injury, which could have caused or contributed to Ms H's death.

The cause of Ms H's death was found to be mixed drug toxicity. The effects of the drugs taken would have caused severe respiratory depression (through the central nervous system) including, muscle rigidity, seizures, coma and hypotension.

Police investigation

Following Ms H's death, an extensive police investigation was undertaken by Detective Sergeant James Steginga from the Wynnum District Criminal Investigation Branch (CIB). A coronial report was subsequently provided, which included statements from an array of witnesses, forensic testing results, CCTV footage, as well as photographs of the scene.

The sequence of events and circumstances of Ms H's death, as previously outlined, is based upon the evidence obtained by police.

Conduct of Dr JS

Records obtained by police from the Medicines Regulation and Quality (MRQ) of Queensland Health confirmed that between 28 April 2011 and 29 August 2011, Ms H had been prescribed Fentanyl and OxyContin tablets on eight different occasions by Dr JS. Each of these

prescriptions had been filled by Ms H. Records also confirmed that Dr JS had been notified by MRQ on two occasions in June and July 2011 not to prescribe Ms H with a restricted drug of dependence or a controlled drug without the requisite regulatory approval and that she was registered on the Queensland Opioid Treatment Program (QOTP). It was recommended that she should be reviewed by an Alcohol and Drug Service to assist in future management and did not have a pain level which required the use of oral opioids.

During the course of the police investigation, a statement was obtained from Forensic Medical Officer, Dr Adam Griffin in relation to Dr JS's treatment of Ms H. Having considered Dr JS's patient records and the findings of the post-mortem report, Dr Griffin concluded that Dr JS had demonstrated inadequate note taking and examination prior to dispensing narcotic drugs. He also acted contrary to the advice provided by MRQ by continuing to prescribe opiate medication to Ms H.

On 29 October 2012, Dr JS was issued with a 'show cause' notice by MRQ. In response, Dr JS did not dispute the fact that he had prescribed Ms H with Fentanyl and Oxycodone despite being aware of her history of opioid dependence and her recent engagement with QOTP. He was aware of his regulatory obligations which clearly required him to obtain prior approval before prescribing Ms H with Fentanyl patches.

Dr JS's conduct was reported to the Australian Health Practitioner Regulation Agency (AHPRA), who subsequently commenced an extensive investigation into the matter.

Domestic Violence History

According to police records, there were three reported instances of domestic violence between Ms H and AO'S.

The circumstances of the instances are as follows:

I. 15 March 2011: Ms H attended the Norman Hotel, Ipswich Road, Woolloongabba seeking assistance from staff stating that she had been assaulted by AO'S. Officers from Annerley Station attended the hotel and after speaking to Ms H determined the deceased and AO'S were not enmeshed. It was determined by police not to proceed with the domestic violence incident report.

II. 20 March 2011: Ms H's mother, Ms RM-P, advised police that she held grave concerns for the welfare of her daughter believing her to be the on-going victim of physical and sexual abuse by AO'S. Officers attempted to interview Ms H about the allegations however, she was drug affected and unable to be interviewed. She declined to provide a statement regarding the physical abuse but verbally advised police officers the abuse was occurring. Based on the verbal statement, officers applied for a Domestic Violence Protection Order, which was granted by the Holland Park Magistrates Court on 17 May 2011. AO'S was present when the order was made.

III. 14 August 2011: Police attended the Birkdale residence in response to a call from Ms H. She alleged that AO'S had attempted to strangle her and that he had threatened her with a knife and stabbed himself. AO'S had left the residence before police arrived. At the time, Ms H was under the influence of liquor and drugs and as such, no statement could be taken from her. The following day, Ms H attended the Capalaba Police Station and advised police that she no longer wished to proceed with any complaint and decline to provide a statement. AO'S presented the following day and participated in a record of interview. He provided a conflicting version of events to that originally provided by Ms H. Further information suggested that AO'S may have been injured by Ms H during the altercation, receiving a cut on his hand as a result. Ultimately, a decision was made to finalise the report as there were conflicting

accounts, a lack of corroborating evidence, and Ms H was no longer cooperative.

AHPRA Investigation

On 6 August 2013, AHPRA confirmed that they were investigating a complaint made in relation to the clinical conduct of Dr JS in respect of Ms H's patient care.

Information obtained by AHPRA indicated that Dr JS had prescribed Ms H with controlled and restricted drugs of dependency on the following occasions:

- Four prescriptions for Oxycodone between 28 April 2011 and 21 June 2011.
- Four prescriptions for Fentanyl between 26 July 2011 and 29 August 2011.
- Three prescriptions for Oxycontin between 28 April 2011 and 7 June 2011.

On 17 June 2011, records from MRQ confirmed that Dr JS was advised that Ms H was known to be drug dependent and that it was unlawful to prescribe to her in the absence of an approval from the Chief Executive. Regardless, he subsequently prescribed Ms H Fentanyl patches on four occasions in July and August 2011. He was also aware that she had been assessed by ATODS and was considered to be drug dependent.

Submissions and statements provided by Dr JS indicate that Ms H presented to him on 27 April 2011, with a history of back pain following an accident several months earlier. She allegedly claimed that she had been prescribed Oxycontin and Xanax before. Dr JS did not consider it necessary on this occasion to obtain MRQ approval. He claimed that he was unaware that Fentanyl could be injected and did not seek approval to prescribe it as it was a new medication, and similar to that previously prescribed. He further asserted that Ms H did not exhibit any signs of being drug dependent or drug seeking behaviour.

Following a review of Dr JS's clinical records it was identified that they did not contain details about assessments, patient history, examinations, management plans or referrals per the principles of good patient care contained in *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

Dr JS's complaints history from the Medical Board of Queensland confirmed that there had been notifications made in 1996 as a result of allegations of writing prescriptions contrary to the *Health Drugs and Poisons Regulation 1996*. No further action was taken on this occasion, pursuant to s. 15(1)(a) of the National Law. In 2006, an investigation was undertaken in relation to possible overprescribing for a drug dependent person under questionable circumstances which resulted in Dr JS entering into an undertaking. Further disciplinary action was then taken in April 2008 as a result of an anonymous complaint which included allegations of inappropriate prescribing.

As a result of the investigation into Dr JS's conduct in relation to Ms H, his endorsement under the *Health Drugs and Poisons Regulation 1996* to prescribe restricted and controlled drugs was cancelled, effective 1 November 2012. At present, he also has restrictions on his registration which require him not to practice outside of Queensland and to inform the Board within seven days of a change of address. These restrictions came about as a result of an immediate action process.

On 31 July 2015, the Performance and Professional Standards Panel, established on behalf of the Medical Board of Australia, imposed the following conditions on Dr JS's registration, pursuant to s.191 of the *Health Practitioner Regulation National Law*, as in force in Queensland:

- The Practitioner must submit to an audit of his record keeping at his practice for the period of twelve months from the date of the imposition of these conditions.

- With 28 days of the imposition of these conditions, the Practitioner must nominate to the Board, a professional colleague registered as a medical practitioner (the Auditor).

- The Auditor must:

    i. Be senior to the Practitioner by either years or by position;
    ii. Agree to the nomination; and
    iii. Be approved in writing by the Board.

- The Auditor will undertake the audit every three months for a period of 12 months from the date of the imposition of these conditions.

- The audit must focus on the Practitioner's record keeping to ensure the Practitioner's ongoing compliance with the RACGP Standards for General Practice, as well as the Board's *"Good Medical Practice: A Code of Conduct for Doctors in Australia"* effective March 2014, in particular, Clause 8.4.1 with regard to maintaining medical records to report relevant details of clinical history.

- The Practitioner must provide reports written by the Auditor to the Board, addressing the Practitioner's record keeping in accordance with condition 5.

As a result of the information obtained during AHPRA's investigation into Dr JS's conduct, the Board directed that the matter be forwarded to the Office of the Health Ombudsman (OHO) for further action.

Family concerns

During the course of the coronial investigation, Ms H's mother, Ms RM-P has raised a number of concerns regarding the circumstances of her daughter's death. Essentially, she asserts that AO'S was abusive towards Ms H and was responsible for her intravenous drug use. She is of the view that AO'S may have assisted in her daughter's death.

I have considered all of the concerns and matters raised by Ms RM-P during the course of the coronial investigation when reaching my conclusions regarding her daughter's death.

Conclusions

LAMH was 31 years of age when she died on or about the 1 September 2011, as a result of mixed drug toxicity. She was found lying on the floor of her residence, with an uncapped syringe containing Fentanyl next to her and a spoon with melted plastic on it on the table nearby. Tragically, Ms H had a long-term history of illicit and prescription drug use for which she had received treatment in the past. Post-mortem toxicology testing confirmed the presence of various illicit and prescription medication, the most significant being Fentanyl which was found to be in the toxic range. Contrary to a direction from MRQ, Dr JS prescribed Ms H with this drug of dependence shortly before her death.

Having considered all of the evidence obtained during the course of the extensive police investigation, as well as the findings of the post-mortem examination, I am satisfied that the circumstances of Ms H's death are well established and do not require clarification by way of further investigation or an inquest. I am satisfied that shortly prior to Ms H's death, she was with AO'S at their residence and they were each injecting themselves with drugs which included Fentanyl. At some point, Ms H has become unconscious on the floor and has then died. At some point, AO'S has placed a towel under her head and covered her partially with a blanket. Upon realising Ms H was deceased, AO'S has fled the residence. At 7.57am, he

called Triple 0 seeking assistance for Ms H from a phone-box near the Manly Railway Station.

While AO'S has not provided a formal statement to police in relation to the circumstances of Ms H's death, the account provided by his lawyer accords with the independent evidence obtained, as well as the post-mortem findings. Although it is clear that Ms H's relationship with AO'S was violent and volatile, there is no basis to reasonably suspect that he or anyone else played any part in her death. Ms H clearly had a long-standing intravenous drug problem which involved the use of illicit and prescription drugs, including opiates. The Fentanyl she injected which, in combination with other illicit drugs and prescription medication, caused her death, were sought and prescribed to her. There is no evidence to suggest that AO'S assisted in Ms H's death or injected her against her will. As such, I am satisfied from the information obtained during the coronial investigation there is sufficient evidence for me to make these findings in relation to the death of LAMH.

The actions taken by MRQ and AHPRA, in relation to Dr JS's prescribing practices and the imposing of other restrictions are appropriate given the circumstances of Ms H's death. It is clear that he prescribed Ms H with Fentanyl on a number of occasions contrary to the directions of MRQ and his regulatory obligations, of which he was well aware. It is appropriate that the matter has been referred to OHO, who I understand are presently considering further action.

Given the established circumstances of Ms H's death, the referral to OHO, and the length of time since the incident, I find that an inquest would not be in the public interest.

I close the investigations.

James McDougal
I, Coroner
Coroners Court of Queensland - Southern Region
30 November 2016