CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF LESLEY MAREE SMITH**
Citation:	[2017] ACTCD 3
Hearing Date:	25 July 2017
Date of Findings:	11 September 2017
Before:	Chief Coroner Lorraine Walker
Legislation Cited:	*Coroners Act 1997* (ACT) ss 52(1), 52(3)
Papers Cited:	Templeton AH. Carter KLY. Sheron N. Gallagher PJ. Verrill C. "Sudden Unexpected Death in Alcohol Misuse—An Unrecognized Public Health Issue?" *International Journal of Environmental Research and Public Health* (2009) 6, 3070-3081; doi:10.3390/ijerph6123070
Appearances and Representation:	Ms Sarah Baker-Goldsmith as Counsel Assisting the Coroner. Ms Katherine Oldfield of Counsel for Dr Helmy instructed by Ken Cush & Associates.
File Number(s):	CD 5 of 2015

CHIEF CORONER WALKER:

Jurisdiction

1. A Coroner is required to hold an inquest into the manner and cause of death of a person who dies a sudden death the cause of which is unknown: see section 13(1)(c) of the *Coroners Act 1997* (ACT) ("the Act") as it was in force at the time.

2. Lesley Maree Smith was a 47 year old woman who died at her residence in Banks in the Australian Capital Territory on 9 May 2013. Her death was not expected, and the cause of her death was not known. However, she had a history of chronic alcohol misuse.

Facts

3. Ms Smith was last seen alive by Dean Lavaki, a family friend who also lived with the family, at her home at approximately 3.10pm on the day of her death. Mr Lavaki reported later to Police that Ms Smith did not appear intoxicated at that time and appeared normal. Ms Smith's partner, Mr Ian Johnson, reported having email communication with Ms Smith during the course of that day while he was at work. The last email communication from Ms Smith to Mr Johnson occurred at about 4.19pm.

4. At approximately 5.30pm that day Mr Johnson returned to the home and found Ms Smith, who appeared passed out in a crouching position behind a door. When Mr Johnson picked up Ms Smith to move her to their bedroom he noticed that she was not breathing. He called Emergency Services on 000 at 5.32pm and commenced CPR under the instructions of the emergency phone operator until ACT Ambulance Service officers arrived at 5.39pm. The ambulance officers were unable to revive Ms Smith.

Interim Findings

5. Under section 52(1) of the Act, a Coroner holding an inquest must find, if possible:

    (a) the identity of the deceased; and

    (b) when and where the death happened; and

    (c) the manner and cause of death; …

    The Coroner must record his or her findings in writing: s 52(3).

6. On 9 September 2013, I made interim findings in relation to Ms Smith's death confirming her identity and the date and place of her death, stating that the manner and cause of her death were unascertained but there were no suspicious circumstances.

Hearing Held

7. Ms Smith had a history of asthma, depression and alcoholism. Ms Smith's use of alcohol in the period leading up to her death had reached an average of two bottles a night. Ms Smith frequently attended the Conder Medical and Dental Centre and from October 2010 was treated primarily by then general practitioner, Dr Gamal Helmy.

8. An hearing was held in the inquest related to the death of Ms Smith was held on 25 July 2017 because after my review of the initial evidence, I was concerned about the potential effect of sedative drugs which had been prescribed by Dr Helmy to Ms Smith. My concerns related to the effect of the drugs in combination with each other, and in combination with alcohol. As to alcohol, I was concerned about the combination of taking sedative medication together with alcohol which in itself is a sedative, along with the effect of the medication on someone with possible liver complications arising from alcohol misuse. These concerns were mostly addressed in the evidence that was made available to me prior to the hearing date. A review of this evidence leads me to find that the combination of the sedatives and alcohol were not the cause of Ms Smith's death.

9. However, I remained concerned as to what contribution, if any, the sedative medication may have made and significantly, whether a matter of public safety arose in relation to the prescription of certain sedative drugs for a prolonged period for a person with a history of alcohol misuse. It is for those reasons that the matter proceeded to hearing on 25 July 2017.

Evidence

10. Police conducted an investigation into the circumstances of Ms Smith's death on my behalf, and I directed that a post-mortem examination of Ms Smith take place. A brief of evidence was compiled by First Constable Serena Wong which included the post mortem examination report of Dr Grant McBride, expert reports from Dr Vanita Parekh about possible causes of Ms Smith's death, and statements from Mr Johnson and Mr

Lavaki. Prior to the hearing the brief of evidence was also supplemented with additional material, including expert reports put forward by Dr Helmy from Dr Michael Robertson, a specialist pharmacologist and toxicologist, and Dr Harry Lowe, a specialist cardiologist; both of these experts gave evidence at the hearing.

11. The hearing commenced with oral evidence from Mr Johnson, who told the Court about Ms Smith's life, what he recalled of some attendances of Ms Smith on Dr Helmy when he accompanied her to the clinic, and the circumstances of how he came to find Ms Smith collapsed on the day she died.

Dr McBride

12. Dr Grant McBride is the pathologist who conducted a post mortem examination of Ms Smith at my direction. Dr McBride's autopsy report concluded that the manner of Ms Smith's death was natural with possible contributory accidental factors. Dr McBride reported that the medical cause of Ms Smith's death was unobserved cardiac arrest and possible seizure or cardiac arrhythmia, along with marked liver steatosis (fatty change) due to or as a consequence of drug interaction/combined effect (diazepam, oxybutynin and alcohol) and cardiac hypertrophy due to or as a consequence of chronic alcoholism.

13. Dr McBride later clarified by email that he strongly suspected that Ms Smith's chronic alcoholism and severe hepatic steatosis left her at considerable risk of an adverse event. Dr McBride also advised that the exact position that Ms Smith was found in should be clarified as positional asphyxia could be an additional contributory component in her cause of death.

14. Dr McBride also confirmed in a later email in response to a question arising from Dr Lowe's report that he saw evidence of left ventricular hypertrophy in Ms Smith's heart, but there was no evidence of hypertrophic cardiomyopathy at autopsy.

Dr Helmy

15. Dr (Mohammad) Gamal Helmy had provided an initial short statement to Police in this matter, but gave lengthy oral evidence at the hearing. Before me Dr Helmy was very forthcoming about the things that in hindsight he could have done better in relation to Ms Smith. I find that he was a genuine and honest witness. I have been advised by Counsel Assisting subsequent to the hearing that Ms Smith's family greatly appreciated Dr Helmy's evidence and comments and I wish to thank Dr Helmy for the cooperative spirit in which he and his representatives approached the inquest.

16. Dr Helmy confirmed that Ms Smith's clinical file indicated that she first started seeing Dr Helmy in October 2010 at which time she did not disclose that she drank alcohol. Dr Helmy agreed that his clinical notes indicate that Ms Smith first disclosed her problems with alcohol to Dr Helmy on 23 January 2013. At that appointment Dr Helmy recorded that Ms Smith declined to self refer to drug and alcohol rehabilitation: he prescribed mirtazipine, which is an anti-depressant and would assist Ms Smith to sleep; and he also referred Ms Smith to a psychologist under a mental health care plan. Dr Helmy confirmed that Ms Smith attended appointments with him on 30 January, 7 February, 13 March and 8 April 2013, and that he did not follow up with Ms Smith whether she ever saw a psychologist but he understood that she did not, never having received a report back from one.

17. Dr Helmy gave evidence that he first prescribed Diazepam (Valium) to Ms Smith on 8 April 2013 and then every week for a total of four weeks. According to Dr Helmy's calculations Ms Smith was overall compliant with the prescribed dose of a maximum of 5 milligrams four times daily, although initially he believed she was non-compliant when providing information to Police. Dr Helmy said that at the time of first prescribing the Diazepam, he explained to Ms Smith that when she started reducing her intake of alcohol she would experience withdrawal symptoms which could manifest specifically as anxiety, insomnia and tremors. Dr Helmy said he told Ms Smith that the Diazepam would control these symptoms and make it easier for her to reduce her consumption of alcohol.

18. According to Dr Helmy, he did not have regard to any professional standards or guidelines or any other documentation related to the prescribing of Diazepam for patients such as Ms Smith who may be withdrawing from alcohol – in fact, he was unaware of any such applicable documents. Dr Helmy stated that it was not his intention for Ms Smith's use of Diazepam to be long-term and he had intended for her reduction in alcohol to come about quickly.

19. Dr Helmy conceded he did not have any particular specialist training in the treatment of patients with drug and alcohol misuse problems, nor did he seek any advice from a practitioner with this training. He conceded that he should have referred Ms Smith to a practitioner with that specialist expertise, and that it was open to him to have refused to treat Ms Smith given his lack of expertise in this area. Dr Helmy said that the reason why he continued to treat Ms Smith was because she had previously declined referrals to other providers but seemed to engage with him for treatment, and he wished to assist her to overcome her alcohol misuse problem.

20. Although Dr Helmy said he advised Ms Smith that the Diazepam would assist with her insomnia once the effects of withdrawal were felt, he agreed that he did not specifically explain to her that this medication was a sedative. He also said that he did not specifically warn Ms Smith about the possibility of drug interactions or adverse side effects.

21. Dr Helmy advised me that he was no longer practicing as a General Practitioner.

Dr Lowe

22. Dr Harry Lowe, a practising clinical cardiologist, was briefed by Dr Helmy to review the records and provide a report. Dr Lowe's key opinions were:

    a. There is no causal relationship between chronic alcohol misuse and hypertrophic cardiomyopathy, but there is such a relationship with another condition called dilated cardiomyopthy. (Dr Parekh also considered this issue – discussed later – but she deferred to Dr Lowe's expertise on this matter.)

    b. While Ms Smith suffered from mild ventricular hypertrophy, she did not suffer from a hypertrophic cardiomyopathy nor any cardiovascular disease that likely caused or contributed to her death. It was later confirmed in an email from Dr McBride that he saw evidence of left ventricular hypertrophy, however there was no evidence of hypertrophic cardiomyopathy at autopsy.

    c. Ms Smith was not at increased risk of arrhythmia generally because of any underlying cardiac condition.

23. Dr Lowe also gave some short evidence before me at the hearing in support of his report, but his ultimate conclusions – that Ms Smith's death was not the result of a cardiac condition – was unaltered from his original report.

Dr Robertson

24. Dr Michael Robertson, an independent pharmacologist and forensic toxicologist, was briefed by Dr Helmy to review the records. Dr Robertson provided two reports in which his key opinions were:

    a. At the time of her death, Ms Smith was prescribed a dose of 15mg daily of Diazepam which is consistent with the established therapeutic range.

    b. The toxicological evidence, together with the appearance of Ms Smith (according to Mr Lavaki) prior to her death, does not support the proposition

that Ms Smith experienced any significant sedation from either diazepam or fluvoxamine either alone or in combination.

c. The drug concentrations found in the blood of Ms Smith do not suggest any direct drug-related toxicity as a cause or contribution to her death.

d. The cause of death was not due to the adverse effects of any of the prescribed medications or due to alcohol intoxication.

25. Dr Robertson also gave some short evidence before me at the hearing in support of his reports, but his ultimate conclusions – that Ms Smith's death was not the result of a drug reaction or interaction – was unaltered from his original reports.

Dr Parekh

26. Dr Vanita Parekh, a clinical forensic medical specialist with qualifications in toxicology and experience in the assessment of deceased persons and consideration of causes of death, prepared a number of reports for me in this matter and also gave short evidence at hearing. According to Dr Parekh's evidence, Lesley Maree Smith's history of chronic alcohol misuse predisposed her to a number of conditions which may have led to her death. Dr Parekh identified these conditions as:

a. Hypertrophic Cardiomyopathy, predisposing Ms Smith to cardiac arrhythmias which may be undetectable at autopsy.

b. Alcohol withdrawal seizures, which may also be undetectable at autopsy. Dr Parekh noted that Ms Smith's blood alcohol level was below the limit of detection in the post mortem sample that was analysed.

c. Collapse with positional asphyxia, which also may not produce any conclusive findings at autopsy.

d. Sudden Unexplained Death in Alcohol Misuse. Dr Parekh noted that the only findings at post mortem of this condition are fatty liver and a negative or low blood alcohol, as was the case of Ms Smith, and this mode of death may have no conclusive findings at autopsy.

e. Toxicity from multiple sedative agents may occur even when each drug may be considered to be in the normal range. Dr Parekh noted that Ms Smith was prescribed a number of medications with sedating properties, including Diazepam, Quetiapine and Oxybutynin, which were consumed in combination with alcohol which also has sedative properties. She stated the sedating effect of medications and alcohol may contribute to falls and positional

asphyxia. [I note however that quetiapine and oxybutynin were not found in Ms Smith's system by the time of autopsy.]

f. Drug interactions, which may also be undetectable at autopsy or in toxicological analysis.

27. In Dr Parekh's opinion, having reference to the report of Dr Lowe, the likelihood of Ms Smith dying from a cardiac condition was very low. Similarly, in Dr Parekh's opinion with reference to the reports of Dr Robertson, the likelihood of Ms Smith dying from some form of adverse drug reaction was low.

28. Dr Parekh stated that there was no good evidence of one specific cause of death in this case; that the cause of Ms Smith's death was multi-factorial. Dr Parekh's final opinion as to the most likely cause of Ms Smith's death was the condition known as Sudden Unexpected Death with Alcohol Misuse ("SUDAM"). She noted that Ms Smith had elevated liver enzymes before death and there was evidence of alcoholic liver disease. Dr Parekh referred to an article published by Drs Templeton, Carter, Sheron, Gallagher and Verrill in relation to SUDAM in the *International Journal of Environmental Research and Public Health* to provide a definition of the condition, as follows (at pages 3078-9):

> ... [s]udden, unexpected, unwitnessed or witnessed, non-traumatic deaths in patients with a history of chronic excess alcohol consumption and evidence of hepatic steatosis or other alcoholic liver disease where post mortem examination does not reveal a toxicological (specifically alcohol intoxication or alcoholic ketoacidosis are excluded) or anatomical cause of death and there is no significant cardiac hypertrophy.

Submissions

29. Following the evidence of Dr Parekh, Counsel Assisting, Ms Baker-Goldsmith, entered into discussions with Ms Smith's family (who had heard the evidence before the court) and Ms Oldfield who represented Dr Helmy. A conclusion was reached between the parties, which was accepted by Ms Smith's family,that no further evidence would assist me to make the findings I was required to make under the Act, as there was clear evidence before the Court that the probable cause of Ms Smith's death was Sudden Unexpected Death in Alcohol Misuse and that additional evidence would be unlikely to take the matter further.

30. Counsel Assisting submitted that while there were concerns over aspects of Dr Helmy's practice, the evidence did not rise to a level where I could make a finding that Dr Helmy's actions were contributory to Ms Smith's death, particularly in light of the evidence of Dr Robinson that Ms Smith's death was unlikely to have been connected to the medications

31. Counsel Assisting noted that the admitted treating practices of Dr Helmy could give rise to a matter of public safety but that in the circumstances of this case these concerns had been extinguished because Dr Helmy was not currently practising. However, Counsel Assisting recommended that the papers and transcript of the hearing be provided to the Australian Health Practitioners Regulatory Agency ("AHPRA") for their consideration as to further action in relation to Dr Helmy was appropriate.

32. It was also suggested by Counsel Assisting that I make recommendations to the Royal Australian College of General Practitioners ("RACGP") in relation to the education of general practitioners on current practices and guidelines for treating drug and alcohol addicted patients in the community.

33. Counsel Assisting suggested that I may also consider making a recommendation in relation to baseline blood testing for patients who are about to commence treatment for drug and alcohol misuse.

34. Counsel for Dr Helmy concurred with the course proposed by Counsel Assisting, save for the suggested referral to AHPRA, in respect of which she made no submission.

Formal Findings, Recommendations and Directions

35. In accordance with section 52(1) of the Coroners Act I make the following findings:

    Lesley Maree Smith (DOB: 21 December 1965) died on 9 May 2013 at 27 Abercrombie Circuit, Banks in the Australian Capital Territory. The cause of Ms Smith's death was Sudden Unexpected Death in Alcohol Misuse.

36. I am required by section 52(4) to expressly consider and state in my findings whether a matter of public safety is found to arise in connection with the inquest. I accept the submission of Counsel Assisting that while certain of Dr Helmy's practices would be of concern were he still practicing, there is no current matter of public safety requiring attention. I also make no adverse comment in relation to Dr Helmy.

37. I make the following recommendation: the Royal Australian College of General Practitioners may wish to consider reviewing the guidance material and education it provides to its members in relation to the treatment of drug and alcohol addicted patients in the community, and specifically in relation to:

    a. current practices and guidelines for treating; and

    b. baseline blood testing for patients who are about to commence treatment for drug and alcohol misuse.

    I direct that a copy of these findings be conveyed to the RACGP.

38. I direct that a copy of my findings in this matter, the transcript of the hearing and all exhibits be provided to the Australian Health Practitioners Regulatory Agency for their consideration as to further action in relation to Dr Helmy was appropriate.

39. Finally, I extend my condolences to Ian, Tyrone, Minarli, Lorraine, Dean, and all of Ms Smith's family and friends on the loss of Lesley.

Chief Coroner Lorraine Walker
11 September 2017

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