# CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

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| **Case Title:** | **Inquest into the death of Lesley Kaye Hasleby** |
| **Citation:** | **[2018] ACTCD 20** |
| **Hearing Date(s):** | 1 July 2014; 12 October 2018 |
| **Decision Date:** | 20 December 2018 |
| **Before:** | Chief Coroner Walker |
| **Decision:** | See [20] |
| **Legislation Cited:** | *Coroners Act 1997* (ACT) |
| **Parties:** | Counsel Assisting the Coroner<br>Dr Stella Kingston |
| **Representation:** | **Counsel**<br>Anna Jamieson-Williams (Counsel Assisting)<br>Robert Hewson (Dr Stella Kingston)<br>**Solicitors**<br>Avant Law (Dr Stella Kingston) |
| **File Number:** | CD 238 of 2011 |

**CHIEF CORONER WALKER:**

1. Ms Hasleby was a 61 year old woman who died on 13 September 2011. Her death falls within the jurisdiction of the coroner in the absence of a death certificate issued by a doctor pursuant to s 13(1)(e) of the *Coroners Act 1997*.
2. The inquest in respect to Ms Hasleby's death has taken a long time to reach its conclusion. A number of factors contributed to this delay which is nonetheless unacceptable. For this, I apologise to Ms Hasleby's family, in particular, her daughter Ms Kylie Coad.
3. Evidence was received at the hearing from Constable Goddard (coronial investigator); Dr Stella Kingston (Ms Hasleby's general practitioner); statements from Mr Keith Hasleby (Ms Hasleby's domestic partner); Ms Kylie Coad (Ms Hasleby's daughter); a number of near neighbours, namely Ms Irene Stergiou, Ms Joanne Irving, Ms Amanda Zafris and Mr George Zafris; Dr Lavinia Hallam (forensic pathologist) and Dr Marcella Cox (expert witness in general medical practice).
4. There is no significant dispute as to the factual circumstances.
5. Ms Hasleby was a vulnerable woman. She had numerous chronic health complaints including liver disease, peripheral neuropathy, depression, alcohol dependence and chronic obstructive airways disease ('COAD'). She was alcohol dependent, a heavy (a pack a day or more) smoker until her death and suffered increasingly impaired mobility. She mentally and physically struggled to leave her

home environment. Whilst she remained in a long-term relationship, it was marred by domestic violence as observed by her neighbours and Ms Coad. She was not well cared for by her Mr Hasleby. Certainly in her later years, they lived in squalor, which was attested to by Ms Coad and by Constable Goddard who attended the home upon receiving notice of Ms Hasleby's death.

6. Ms Hasleby had a relationship with her general practitioner, Dr Kingston, whom she had been seeing since 1988. During that time she was prescribed to dothiepin (a tricyclic antidepressant); oxazepam; a benzodiazepine; Panadeine Forte for arthritis and peripheral neuropathy; and Ventolin and Seretide puffers for respiratory disease. Whilst Dr Kingston had seen the Ms Hasleby on many occasions, her notes are often scanty and she regularly provided prescriptions upon a telephone request and without review.

7. A report prepared by Dr Lavinia Hallam following post-mortem examination of Ms Hasleby's body concluded that there were no morphological findings to readily account for death; there was no evidence of inflicted injury or assault. Dr Hallam held some concern regarding the results of blood toxicology, which disclosed oxazepam at 0.71 mg/L and a low level of methyl alcohol. Whilst the oxazepam was within the therapeutic range, toxic effects have been noted at therapeutic doses in some individuals. Dr Hallam observed that Ms Hasleby's degenerative muscle disease could have conceivably exacerbated the effects of the benzodiazepam. Dr Hallam also noted that "the lungs were emphysematous. The lungs showed generalised collapse and moderate congestion and oedema but showed no gross focal abnormality."

8. In light of Dr Hallam's report, and given the evidence of Dr Kingston in the first phase of hearing in this inquest, a report was sought from an expert in general practice. After some significant delay, Dr Cox was identified as such an expert. She has 24 years' experience as a general practitioner; works part-time for the Medical Council of New South Wales conducting hearings in respect to professional colleagues; and also the Royal Australian College of General Practitioners setting standards, assessing examinations and undertaking professional service reviews.

**Medication Regime**

9. Dr Kingston continued to prescribe dothiepin and oxazepam, each of which could cause respiratory depression against a background of respiratory decline without in-person review. In fairness, Dr Kingston noted that she had sought to reduce Ms Hasleby's reliance on these drugs, particularly oxazepam, over the years but that Ms Hasleby was resistant and few other options were available to her to address the complex health picture.

10. Dr Cox was particularly concerned about the ongoing prescription of oxazepam, which is known to be addictive and is more appropriate for short-term use. She also observed that the both dothiepin and oxazepam cause central nervous system depression, or sedation, and that it would trigger a warning if both were to be prescribed for a patient. Noting how difficult it can be to wean a person off oxazepam, Dr Cox observed:

> "the main things to do are, obviously, over a number of consultations, to talk to the patient about the risks. To talk to the patient about the options of weaning. And usually weaning the benzodiazepines means dropping their doses very gradually over a number of months even. And having a contract with the patient that they agree to do that and that they won't escalate their dose again. It is very difficult to do. Sometimes the other option is to swap them onto something else that helps with anxiety, such as an SSRI medication… It is appropriate at times to refuse requests by patients".

**Failure to Review Following Blood Test Result**

11. Dr Kingston last saw Ms Hasleby on 24 June 2011. A blood test was taken on that day. The results of that blood test indicated hypoxia. It also evidenced a continuing long-term decline. Dr Kingston did not seek to review Ms Hasleby when those results were obtained because she was "not surprised".

12. Dr Cox considered that whilst this was not an enormous deterioration over the previous year, such as would have warranted immediate hospitalisation, she certainly would have wanted to see a patient suffering this decline within a few days. If the conclusion had been reached that the patient was hypoxic, further treatment may have been indicated such as hospitalisation, home oxygen (although noting that this is not suitable for a person who continues to smoke), medication for underlying lung disease or specialist review. Dr Kingston noted that Ms Hasleby was at times reluctant to accept advice; Ms Coad noted that Mr Hasleby's influence may have discouraged Ms Hasleby from more proactively engaging with her own health care.

13. Ms Hasleby's reluctance to accept or act on medical advice does not justify a medical practitioner abandoning efforts to provide it whilst the patient remains a patient.

**Telephone Prescription**

14. Ms Hasleby requested and was given further prescriptions by telephone on 12 September 2011. These were issued by Dr Kingston without review. Dr Kingston accepted that had she reviewed Ms Hasleby then it was possible that there would have been a different outcome. In particular, she accepted that any deterioration in Ms Hasleby's respiratory condition would have been apparent at such a review.

15. Dr Cox noted that telephone prescription is accepted medical practice for patients with stable medical conditions. There were and are no strict guidelines as to how frequently a patient must be seen in person. Dr Cox was concerned more broadly, however, that there was very little evidence of clinical review or monitoring of Ms Hasleby's serious medical conditions. For example whilst there were intermittent blood tests in relation to the chronic liver disease, there were no notes of important clinical assessments such as oxygen saturation levels or chest examinations. This observation was made across the period in which Dr Kingston was Ms Hasleby's general practitioner having regard to the medical notes. It correlated with Dr Cox's opinion in relation to the period proximate to Ms Hasleby's death. She said:

> "I think that my main criticism of that period (the 3 months leading up to Ms Hasleby's death) was the lack of response to the blood test that suggested that she may have worsening hypoxia. So whilst it is common practice to give prescriptions based on telephone requests, and essentially this period of time was when this-there was only telephone requests that were given out, it-that practice is not-not necessarily a concern, as long as the patient is stable and there is no reason to think that anything has changed in the clinical condition. But the fact that the blood test suggests that there had been some change that is what I would be critical of. That the patient needed to be reviewed at that period of time. And be assessed and have her lungs checked, her oxygen checked. Whether or not that would have done anything to change the outcome, I don't know."

16. Given the further information available to her at the hearing, in particular the post-mortem examination results, Dr Kingston was satisfied that Ms Hasleby had in fact died as a result of respiratory failure consistent with end-stage COAD.

**Conclusion**

17. The medical care Dr Kingston provided to Ms Hasleby was sub-optimal.

18. Whilst noting the complexity of her presentation both medically and socially, the drug regime prescribed for Ms Hasleby was contraindicated having regard to her conditions, particularly the COAD. Despite that, no conclusion can be drawn as to the contribution of this prescription regime to Ms Hasleby's death.

19. Dr Kingston's failure to insist on a personal review of Ms Hasleby before prescribing further medication on 12 September 2011, particularly in light of the worsening hypoxia evidenced by the blood test, was inappropriate. However, it is not established that the lack of adequate medical intervention contributed to Ms Hasleby's death.

20. It is reasonable to conclude that a combination of Ms Hasleby's social situation and reluctance to engage in more proactive medical intervention reduced her prospects of a better outcome. Dr Kingston prescribed a potent cocktail of central nervous system depressant medications for a very long time. This continued in the period proximate to Ms Hasleby's death by telephone without adequate review in the presence of cogent evidence of respiratory deterioration. To this extent, an opportunity to intervene in relation to Ms Hasleby's deteriorating medical condition was lost.

## Formal Findings

21. Pursuant to s 52(1) of the *Coroners Act 1997*, I make the following findings:

    (a) The deceased is Lesley Kaye Hasleby, born on 25 August 1950. The deceased died at 39 Majura Avenue, Dickson, in the Australian Capital Territory on or around 13 September 2011.

    (b) The cause of death is respiratory failure consistent with end stage chronic obstructive airways disorder. The manner of death is unascertained.

    (c) Pursuant to s 54(2), I find that no issue of public safety arises. Whilst I find that Dr Kingston's treatment of Ms Hasleby was sub-optimal, Ms Hasleby was a difficult patient who failed to act in her own best interests. Dr Kingston's acceptance of her error indicates that she has learned from and is unlikely to replicate the errors demonstrated in her treatment of Ms Hasleby.

    (d) Noting the evidence of Dr Cox, I direct that a copy of these findings be conveyed to her and to the Royal Australian College of General Practitioners. The College may wish to provide guidance to its members on appropriate parameters for renewing prescriptions for patients without a face to face review, particularly when in possession of evidence of decline in their health status.

I certify that the preceding 20 numbered paragraphs are a true copy of the Findings of her Honour Chief Coroner Walker.

Associate: R. Boughton

Date: 20 December 2018