CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into death of Kurt Mellick Andriske**
Citation:	**[2019] ACTCD 11**
Findings Date:	20 September 2019
Before:	**Acting Chief Coroner Theakston**
Decision:	See [27]-[29].
Catchwords:	**CORONIAL LAW** – Cause and Manner of Death – benzodiazepine dependence – illicit drug user – prescription drugs – diagnosis – septicaemia – whether drugs inappropriately prescribed
Legislation Cited:	*Coroners Act 1997* (ACT) s 13(1)(e)
File Number:	CD 296 of 2016

ACTING CHIEF CORONER THEAKSTON:

1. The death of 52 year old man Kurt Mellick Andriske was reported to the ACT Coroner on 8 December 2016 in accordance with s 13(1)(e) of the *Coroners Act 1997*. No doctor provided a death certificate as to the cause of Mr Andriske's death.

Facts

2. Mr Andriske was born in 1964. Not much is known of Mr Andriske's life prior to 2006, when he started seeing general practitioner Dr Helen Wessell. Mr Andriske was being treated by Dr Wessell for the following conditions: bipolar disorder, neuropathic pain, Hepatitis B and C, and chronic airways disease. Dr Wessell prescribed him number of medications including Valium, Serepax, and Lithium. Medicare records suggest that Mr Andriske saw Dr Wessell (or in her absence, other doctors in her practice) virtually exclusively during the period September 2012 to December 2016.

3. Dr Wessell described Mr Andriske as presenting with thought disorder, poor personal hygiene, and an unreliable source of his medical history. Mr Andriske reported having had a craniotomy in 1995 for an epidural haematoma, possibly from an earlier assault with a cricket bat. Dr Wessell believed that Mr Andriske suffered from permanent acquired brain damage following this incident. Mr Andriske also reported being a heavy drinker and smoker, and some illicit drug use. Dr Wessell was unaware of the extent and detail of the use. However, Mr Andriske denied using intravenous heroin during the period immediately before his death.

4. Mr Andriske was also known to ACT Mental Health services due to an Intensive Care admission at The Canberra Hospital in September 2008 for lithium toxicity. Mr Andriske's mental health was managed in the community by Dr Wessell but ACT Mental Health were advised when Mr Andriske was hospitalised in February 2014 and July 2015 for psychotic episodes. Their last record of engagement with Mr Andriske was on 7 September 2016, when one of Mr Andriske's friends advised

workers in the Needle & Syringe program of concerns about Mr Andriske's safety. A mental health worker called Mr Andriske to check on his welfare. Mr Andriske reported that he had used heroin and taken Valium, but denied any suicidal intention. As Mr Andriske appeared to be coherent and not at immediate risk, no further action was taken.

5. For several months prior to December 2016 Dr Wessell was concerned about an apparent decline in Mr Andriske's health due to his loss of weight. She suspected that Mr Andriske had a liver problem, and referred him for a liver ultrasound on 9 November 2016.

6. On 7 December 2016 Mr Andriske was visited at his residence by a friend, MW, at about 9:30am. Mr Andriske left the residence a short time after to go to the doctor.

7. Mr Andriske saw Dr Wessell that day at 10:47am. He told Dr Wessell that he had not been able to get the ultrasound done as he could not get to the facility to have it performed. In her statement Dr Wessell described Mr Andriske as 'appearing sick' at this consultation, although the relevant medical record does not indicate any particular presenting problem. Dr Wessell referred Mr Andriske for a chest x-ray, and 'urged' him to go to hospital to the Emergency Department. Mr Andriske said that he might go, but Dr Wessell doubted that he would follow through.

8. Mr Andriske returned to his residence at about 11:30 am. MW briefly left the residence a short time later, returning at about 1:00pm. Upon MW's return, they observed Mr Andriske injecting himself intravenously in the left arm near his elbow. MW suspected the substance was heroin. MW also observed Mr Andriske take 'a lot' of prescription medication during the afternoon, after which he became unresponsive. MW offered Mr Andriske Narcan Naloxone, which would have the effect of reversing an overdose of opioids. However, Mr Andriske did not respond. MW thought Mr Andriske was asleep and left the residence. MW observed Mr Andriske laying on the floor between the kitchen and living room.

9. MW returned to Mr Andriske's residence at about 10:30am on 8 December 2016, and observed the screen door was open. That was not normal. MW opened the main door with a key, and observed Mr Andriske lying on the couch with vomit on his face. Mr Andriske did not have a detectable pulse. MW called an ambulance. Ambulance officers arrived and determined that Mr Andriske was deceased, and called Police.

10. Police advised Dr Wessell of Mr Andriske's death that day. She indicated that in the circumstances she would not sign a death certificate for Mr Andriske.

11. A post-mortem examination of Mr Andriske was directed by Chief Coroner Walker. Associate Professor Jain opined that Mr Andriske died from septicaemia caused by Streptococcus Milleri group pneumonia, but that the combined toxicity of a number of prescription and non-prescription drugs was a significant condition contributing to death, although not related to the disease or condition causing death. The autopsy examination showed organising pneumonia and abscess formation in the left upper and lower lobes, and the right upper lobe of Mr Andriske's lungs. Post mortem toxicology showed the presence of multiple substances including Codeine, Tetrahydracannabinol, Diazepam, Morphine, 6-Monoacetylmorphine, Diazepam, Oxazepam and Temazepam. Lithium and alcohol were not reported as detected.

12. I note that due to a very quick metabolism rate in the body, heroin is very rarely detected in toxicology testing. However, 6-Monoacetylmorphine is a unique metabolite of heroin and its detection evidences recent heroin use. Heroin is also broken down in the body to Morphine and Codeine, but toxicological testing is not presently at a level where it can identify whether these substances were consumed separately or are just the breakdown product of heroin.

Medical Review

13. Chief Coroner Walker directed that a review of Mr Andriske's records be undertaken to consider the appropriateness of the medications he was prescribed, whether there was any evidence of suicidal ideation or self harm attempts, and whether there were any relevant matters going to manner and cause of death, or a matter of public safety.

14. Associate Professor Vanita Parekh undertook the medical review and prepared a report for the assistance of the Coroner. The Associate Professor is a Senior Staff Specialist in a speciality of forensic medicine, and holds a Diploma of Medical Toxicology.

15. Associate Professor Parekh noted that Mr Andriske consumed medications that were not prescribed to him such as Temazepam, which was detected at post mortem. She queried the co-prescription of Oxazepam and Diazepam to Mr Andriske, saying that there was no clinical indication documented in the medical records for this co-prescription, and that she could not ascertain any indication generally in the records. She observed that Lithium increases the toxicity of Diazepam and should be used with caution.

16. Associate Professor Parekh noted that benzodiazepine medication such as Oxazepam and Diazepam are commonly diverted and misused, and that one way to mitigate this risk is to ask the patient to voluntarily sign a 'benzodiazepine contract'. That is where the patient makes undertakings in relation to their substance use, for example to not attend upon other doctors and to attend only a single pharmacy for dispensing of prescriptions. She observed that while Dr Wessell appeared to have discussed such a contract with Mr Andriske on 9 July 2015, no such contract appeared to have been put in place.

17. Associate Professor Parekh noted that while Mr Andriske had been recorded as attempting suicide in 1995 and had expressed thoughts of suicide in 2014, there was no documented evidence of suicidal ideation described in the medical records for the two years prior to Mr Andriske's death.

18. Associate Professor Parekh observed that Mr Andriske had multiple medical conditions that were complex and clinically challenging to manage. She observed that coordinated care plans, which involved a number of different medical and social specialities, were essential in cases such as this. She also noted that this type of case management is challenging without the agreement of the patient, and that the medical records documented that Mr Andriske had been offered support and counselling on multiple occasions and refused it.

19. I directed that Dr Wessell be provided a copy of Associate Professor Parekh's report, and that she be asked to provide comment. Dr Wessell provided me with a short written statement in which she expanded upon the information she had provided police shortly after Mr Andriske's death.

20. Dr Wessell stated that she prescribed Mr Andriske Valium (Diazepam) for anxiety and panic during the day, and Serepax (Oxazepam) at night for insomnia, as Mr Andriske reported that Valium did not help him sleep. She said that she was aware that this was outside of the regular guidelines, but felt both then and now that these medications were appropriate for his presentation and kept his symptoms to a manageable level.

21. Dr Wessell said she was aware of risks from co-prescribing Valium and Lithium, and the combination of Lithium and alcohol use. She managed those risks by monitoring Mr Andriske's blood Lithium levels closely. She said that Mr Andriske's Lithium levels were generally in or below therapeutic levels. Dr Wessell also said that she had warned Mr Andriske about the potential for other medications and substances to interact with his prescriptions.

22. Dr Wessell stated that Mr Andriske was not prepared to enter into a 'benzodiazepine contract', but had assured her that he only received prescriptions from herself. Dr Wessell considered that Mr Andriske was dependent on benzodiazepines, and generally stable in terms of his condition and dosages. It was her usual practice to prescribe Mr Andriske enough medication for one month, provide a post-dated script, and require Mr Andriske to attend upon her monthly to receive new scripts. That was to ensure that Mr Andriske did not access too much medication at once. She was reluctant to try to wean Mr Andriske off benzodiazepines because he was a long term user and she was aware that withdrawal can precipitate seizures. It also risked Mr Andriske resorting to other, even less desirable means, of self-medication.

23. Dr Wessell said that she repeatedly urged Mr Andriske to have chest x-rays and abdominal ultrasounds, but he declined. She said that Mr Andriske could not be forced to take his medication or receive other treatment. She opined that it could be dangerous to force treatment upon him. She stated that she endeavoured to care for Mr Andriske to the best of her ability and to improve his quality of life, while respecting his rights as an individual to make his own fully informed choices.

24. Dr Wessell said that she did not believe that Mr Andriske was deliberately suicidal but he was unconcerned about the known risks of his lifestyle. Reflecting on his death, Dr Wessell commented:

> In the light of [Mr Andriske's] aversion to hospitals or any authority, I think it highly likely that he was feeling so unwell [that] he didn't care what happened and engaged in risky behaviour with full awareness and in preference to seeking medical intervention.

25. Dr Wessell agreed with Associate Professor Parekh's comments in relation to the desirability of co-ordinated care, but noted that Mr Andriske refused to have anything to do with social or mental health services, and would not on any account attend the Drug & Alcohol Service. She commented also on the limited services readily available within the community, and the burden on GPs when taking on psychiatric management of patients.

Considerations and Findings

26. In all the circumstances, in my view there is no benefit in holding a public hearing in relation to Mr Andriske's death.

27. Having considered the police report, post-mortem examination report, the brief of evidence prepared by the coronial investigator, statements from Dr Wassell and an expert review of Mr Andriske's medical history, I make the following findings:

    (a) Kurt Mellick Andriske died sometime between the afternoon of 7 December 2016 and the morning of 8 December 2016 at Unit 17, Block 20, Northbourne Flats, Henty Street, Braddon in the Australian Capital Territory.

    (b) The manner and cause of Mr Andriske's death is septicaemia caused by Streptococcus Milleri group pneumonia, and his death was contributed to by the combined toxicity of a number of prescription and non-prescription drugs (misadventure).

28. There is no evidence to suggest that the substances in Mr Andriske's system identified after death were taken by him with the intention of ending his own life, and I make no finding of suicide. I agree with Dr Wessell that Mr Andriske's death in this regard was likely the result of misadventure.

Matters of public safety

29. Given Dr Wessell's explanation of the reasons why Mr Andriske was co-prescribed Oxazepam and Diazepam, I find that this was not an unreasonable prescription in the circumstances. The reason for the co-prescribing could have been better articulated in Dr Wessell's notes, but in the context of Mr Andriske being a long term, regular patient of Dr Wessell, I make no adverse comment or finding in that respect. I further make no adverse comment or finding against Dr Wessell in any respect of her treatment of Mr Andriske. It appears she did the best she could with a complex patient. I agree it is likely that Mr Andriske would have self-medicated with other substances had Dr Wessell refused or tightened the conditions of treatment. At the last consultation, Dr Wessell appropriately referred Mr Andriske to hospital in respect of his deteriorating health.

30. No matter of public safety arises in relation to Mr Andriske's death, and accordingly I make no recommendations in this matter.

31. I direct that these findings be published in due course on the Coroner's Court website.

32. I extend my condolences to Mr Andriske's family and friends.

I certify that the preceding thirty-two [32] numbered paragraphs are a true copy of the Findings of his Honour Acting Chief Coroner Theakston

Associate: Priyanka Koci

Date: 20 September 2019