CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into death of RODNEY WAYNE RUDD**
Citation:	**[2020] ACTCD 3**
Findings Date:	7 February 2020
Before:	**Coroner Morrison**
Decision:	See [6]-[7], [19]-[23].
Catchwords:	**CORONIAL LAW** – cause and manner of death – opioid-dependent patient – whether actions of treating practitioners appropriate – no matter of public safety – hearing unnecessary
Legislation:	*Coroners Act 1997* (ACT), s 13(1)(a), 34A, 52, 55
File Number:	CD 255 of 2015

CORONER MORRISON:

1. The death of Rodney Wayne Rudd, a 67 year old man at the date of his death, was reported to me as he was thought to have died unnaturally in unknown circumstances. Mr Rudd was located deceased on the floor of the toilet of his residence at about 8:30pm on 17 December 2015 by members of his family. Mr Rudd had last been seen alive by a neighbour on 13 December 2015. He had been deceased for some period of time before his discovery.

Investigation

2. Mr Rudd had a complicated medical history. In the period before his death he suffered from pancreatitis, osteoporosis and early emphysema; he also struggled with chronic pain due to degenerative bone issues. In the past Mr Rudd had been a heavy smoker (to 2007) and drinker (to 2000). Mr Rudd had been prescribed medication by his general practitioner, Dr Sivan Rasaratnum at the Tuggeranong Square Medical Practice, for his conditions.

3. Many packets of prescription and non-prescription medication were located and seized in Mr Rudd's residence by Police after his death, including MS-Contin, Zircol, Creon, Aderson, Zimstat, Voltaren, Codapane Forte, Fenac, Cymbalta, Metoclopramide, Lyrica, Fonat, Ordine, Actonel, Diazepam, Salpraz, Spiriva, Atacand, and Alendro.

4. I ordered that a post mortem examination of Mr Rudd take place, including toxicological testing of blood and urine samples. Associate Professor Sanjiv Jain conducted the examination and opined that Mr Rudd died from aspiration of gastric contents, due to morphine toxicity. A/Professor Jain also noted that Mr Rudd suffered from bilateral marked bullous emphysema as a condition which contributed to death but was not related to the condition or disease that caused death. Although the state of Mr Rudd's body made examination difficult, free Morphine and total Morphine were found at levels that had been reported in other cases as being therapeutic and/or toxic and/or lethal. (I understand that all three levels commonly overlap for opioid substances due to the tolerance which can develop in long term users.) Diazepam and its metabolite Nordiazepam were found at low levels, as was alcohol (which can be produced by the body after death and does not necessarily indicate consumption).

5. Advice from the ACT Government Analytical Laboratory is that the presence of Morphine in blood can be an indicator of Morphine use, Heroin use, Codeine use, Pholcodine use or the consumption of poppy seeds; however, in the event of Heroin or Codeine use, metabolites of these substances may also been seen in the blood. I note that Police located the following Morphine and Codeine containing medications in Mr Rudd's residence after his death:

    a. MS-Contin CR 10 mg (Morphine): 5 packs of 28 tablets, and 1 pack with 1 tablet remaining;

    b. MS-Contin 15 mg (Morphine): 1 pack with 23 tablets remaining;

    c. Ordine 5 mg (liquid Morphine): a 200 ml bottle with 102 ml remaining

    d. Codapane Forte 500/3 mg (Paracetamol and Codeine): 26 packs of 20 tablets

    All of the above medication had been prescribed to Mr Rudd by Dr Sivan Rasaratnum at the Tuggeranong Square Medical Practice.

6. I am required by section 52(1) of the *Coroners Act 1997* to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. Accordingly I find that:

    Rodney Wayne Rudd died on a day between 13 and 17 December 2015 at Unit 6, 3 Pennington Crescent, Calwell in the Australian Capital Territory. The cause of Mr Rudd's death was aspiration of gastric contents, due to morphine toxicity, in the context of bilateral marked bullous emphysema.

7. I make an open finding as to manner of death. There was no evidence located suggesting suicide. While the existence of high levels of Morphine in Mr Rudd's blood might suggest the non-accidental consumption of high levels of medication, I note also that Morphine does have an intoxicating effect such that a person might accidentally consume more than intended.

Potential Matter of Public Safety

8. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it.

9. The amount of prescription opioid medication located in Mr Rudd's residence, together with the presence of those medications in his blood, gave me concern.

I directed that records be obtained from Medicare and the Pharmaceutical Benefits Scheme (PBS) to show Mr Rudd's attendances at doctors and the prescriptions he had filled for medication. Those records showed that in the last four years and save for various speciality consultations Mr Rudd exclusively saw Dr Rasaratnum at the Tuggeranong Square Medical Practice, and Dr Edwin Cassar at the Chronic Care Centre in Garran. There is no evidence to support that Mr Rudd was a 'doctor shopper' in the way that term is conventionally understood. I then directed that these doctors provide written statements as to their treatment and care of Mr Rudd, and I issued subpoenas to obtain Mr Rudd's medical records. Both doctors provided information to assist my investigation.

10. Dr Rasaratnum stated that he had been treating Mr Rudd since 1999 for many conditions. He said that he had prescribed opioid medication for Mr Rudd for many years under the direction of pain specialist Dr Cassar. Dr Rasaratnum said that Mr Rudd would see Dr Cassar once or twice a year for review and that Dr Cassar would send recommendations to him (Dr Rasaratnum) to follow in relation to narcotic analgesics. Dr Rasaratnum said that Mr Rudd had been prescribed MS-Contin for more than 15 years and at times Mr Rudd had been taking more than 80 mg of that medication a day. Dr Rasaratnum said that he would only issue Mr Rudd with a one-month supply of narcotic based drugs at a time. He said that while he did not recall specific conversations, he had spoken with Mr Rudd about taking prescribed medications as directed.

11. Dr Cassar stated that he had first met Mr Rudd around 15-20 years ago when Mr Rudd had been admitted to John James Hospital. Subsequently Dr Cassar worked with Mr Rudd's GPs in the treatment of Mr Rudd's pain. Dr Cassar said that it was only in the last five to ten years that he considered Mr Rudd's pain issues were dealt to Dr Cassar's satisfaction, and accordingly for the last five years he had been seeing Mr Rudd on an annual basis. He said that during the last five years he assessed that Mr Rudd was following doctors' orders including using Schedule 8 (drugs of dependence) medications for pain relief appropriately. Dr Cassar stated that in the last three years Mr Rudd had reached a stage where gradual reduction of his painkiller doses could be attempted, but Mr Rudd also retained a supplementary Morphine liquid supply (Ordine) that he could use for breakthrough pain, which was a common practice for patients reducing their pain medications.

12. Dr Cassar last saw Mr Rudd in August 2015 at which time he recommended a change to Mr Rudd's maintenance doses to 15mg MS-Contin twice daily – a reduction from 15 mg in the morning and 20 mg at night. Dr Cassar opined that Mr Rudd's use of the supplementary Morphine liquid supply was consistent with the amounts recommended and considered acceptable by himself and Dr Rasaratnam. He said that Mr Rudd was normally very conscientious and cooperative with his medication use, but at the last appointment he noticed that Mr Rudd appeared depressed.

13. Dr Rasaratnum said that in the period immediately before Mr Rudd's death he was seeing Mr Rudd for monthly appointments to issue painkiller medications and other medications associated with osteoporosis and blood pressure. The records of treatment show that the second last consultation with Mr Rudd was on 2 November 2015. The records show that Dr Rasaratnum printed scripts for Diazepam, Lyrica (for nerve pain), Ordine and MS-Contin 10 mg. The note on the record is "discussed pain management". PBS records show that Mr Rudd filled those scripts the same day at the Soul Pattinson Pharmacy at Tuggeranong Hyperdome.

14. The records show that Dr Rasaratnum's last consultation with Mr Rudd was on 30 November 2015. At that time Dr Rasaratnum printed repeat prescriptions for MS-Contin (both 10 mg and 15 mg tablets), Diazepam and Fosamax (for osteoporosis). He noted in the record that Mr Rudd's MS-Contin dose had changed to 25 mg overall per day, and that Mr Rudd was "coping with pain". PBS records show that Mr Rudd filled those scripts the same day at the Soul Pattinson Pharmacy at Tuggeranong Hyperdome.

15. The records generally bear out Dr Rasaratnum's statement that opioids were prescribed monthly for not more than monthly doses, with two exceptions:

    a. Ordine was prescribed at roughly two monthly intervals; and

    b. Codapane Forte was last prescribed on 10 July 2015 by Dr Rasaratnum with five monthly repeats, and Mr Rudd filled that script every month.

16. Dr Cassar's record of his consultation with Mr Rudd on 14 August 2015 takes the form of a letter to Dr Rasaratnum. In that letter Dr Cassar reports that Mr Rudd's "back-up supply of Morphine mixture is only minimally used in recent times". I infer that to be a reference to the liquid Morphine (Ordine) intended to be

available for use for breakthrough pain. However, Dr Rasaratnum's records show that Mr Rudd is prescribed (and dispensed) Ordine in 2015 on the following dates: 23 February, 20 April, 15 June, 31 July, 7 September and 2 November.

17. Overall, the picture illustrated by the evidence is one of Mr Rudd having his medication dispensed on the first available opportunity and stockpiling his medication, whether he needed it or not. I note particularly in this regard the 520 tablets of Codapane Forte located in Mr Rudd's residence by Police. Additionally, the information apparently provided by Mr Rudd and referred to by Dr Cassar in his letter of 14 August 2015 may well have been true at the time, but the evidence of continued prescribing and a half empty bottle being found by Police (having been dispensed approximately one month earlier) suggests that Mr Rudd's Ordine use was approaching the maximum limit of 3 ml per day in the period before his death.

18. Mr Rudd was undoubtedly a complex patient to manage. He was prescribed many different medications, some of them at high dose levels. The coronial investigation has been limited to those capable of producing the Morphine detected in the toxicological screening and identified as contributing to death.

19. The evidence does not rise to a level where any adverse comment is warranted against Drs Rudd and Cassar for their treatment and care of Mr Rudd. Mr Rudd had been placed on a complex prescription regime that he had apparently managed successfully for many years, and for much of that time he had been prescribed higher doses of opioid medication than in the period immediately before his death.

20. While statements that he was conscientious and cooperative with his medication do not sit neatly with my finding that Mr Rudd stockpiled his medications, it is evident that Mr Rudd was aware of the risks of the medications that he took. I find that no matter of public safety arises in this case.

21. ACT Coroners have commented in many recent cases about the difficulties of treating opioid-dependent patients and the dangers that can arise from too-readily available prescription medication. The circumstances of Mr Rudd's case are different. I make no recommendations in relation to this matter.

22. In all the circumstances, in my view there is no need to hold a public hearing in relation to Mr Rudd's death. I believe I have all the evidence which exists or is likely to exist which could possibly bear on the decisions I make.

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

24. I extend my condolences to Mr Rudd's family and friends.

DATED 7 February 2020

P.J. MORRISON
CORONER