

SOUTH



AUSTRALIA

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 12th of June and 16th July 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Mary Brady.

I, the said Coroner, find that Mary Brady, aged 64 years, late of Unit 2, 2 Second Avenue, Payneham South, South Australia, died at Payneham South on the 15th of January 2000 as a result of haemorrhagic bronchopneumonia complicating Doxepin overdose.

1. **Introduction**

1.1. On 15 January 2000, Mrs Brady was found by her daughter, Mrs Jayne Argue-Grose, laying on the floor of the bedroom of her house. An ambulance was called, but it was apparent that Mrs Brady had died. The police were called to the scene.

1.2. First Class Constable Darren Goodall said that he saw a 'number of empty tablet packets scattered on the bed' which, he had been informed, had been found underneath Mrs Brady by the Ambulance Officers. Included in the medication were:

- 1 packet of Zoloft (Sertraline), 28 tablets of 50mg, still intact;
- 1 packet of Sinequan (Doxepin), 25 capsules with 3 remaining;
- 5 packets of Mogadon (Nitrazepam), 12 tablets, empty;
- 3 empty boxes of Mogadon dated 14 November 1999, 9 December 1999 and 17 December 1999.

1.3. Also found in a cane basket was more medication, including Sinequan tablets which were unused.

1.4. No note or other evidence which would explain how, and in what circumstances, Mrs Brady had died was found at the scene.

1.5. Cause of Death

A post mortem examination was performed on the body of the deceased by Dr R A James, Chief Forensic Pathologist on 17 January 2000. Toxicological analysis of the blood disclosed that it contained:

- 0.97mg doxepin per litre (fatal level);
- 0.18mg sertraline per litre (non-toxic/therapeutic level);
- 0.94mg 7-aminonitrazepam per litre (uncertain significance);
- 0.090% alcohol.

(Exhibit C3a)

1.6. Dr James concluded that the cause of death was:

- ‘1. Haemorrhagic bronchopneumonia complicating;
2. Doxepin overdosage.’

(Exhibit C2a, p1)

He described the quantity of Doxepin consumed as a ‘clear overdosage’.

2. Background

2.1. Mrs Brady had been attending the Marden Medical Clinic since 1988. Since 1992, she had been treated by Dr Prudence Sergeant for conditions including hypertension, high cholesterol, fluid retention and osteoporosis.

2.2. Dr Sergeant told me that Mrs Brady had been taking Mogadon for the last 15 years for insomnia and, since 1988, had been prescribed Sinequan from time to time as an anti-depressant (T7).

2.3. On 14 April 1999, Mrs Brady consulted Dr Sergeant seeking a referral to Professor Johann Schioldann, a Consultant Psychiatrist. She had recently been discharged from the psychiatric unit at the Royal Adelaide Hospital, having attempted suicide on 5 April 1999, following the death, by suicide, of her

estranged husband in mid March 1999. Mrs Argue-Grose had found her on that occasion as well.

- 2.4. Dr Sergeant duly referred Mrs Brady to Professor Schioldann, writing him a letter dated 14 April 1999 in the following terms:

‘Thank you for seeing this lady who was admitted to the RAH on 5/4/99 after her daughter found her nearly drowned in her bath after taking alcohol and nitrazepam. About 3 weeks prior to this she had found the body of her ex-husband after he had shot himself and then later had to identify the body. She has a medical history of:

1994 small CVA
osteoarthritis Cx spine
hypertension

Current medication is:

adalat oros 30mg once dly
nitrazepam 5mg once nocte (>20yrs)
caltrate 600mg once dly
solprin 300mg ½ dly

She has also been on sinequan 25mg nocte in the past. She is currently staying with her daughter. Can you please assess and manage her further?’

(This letter is part of Exhibit C6a)

Note that Dr Sergeant referred to Mrs Brady having taken Sinequan (Doxepin) in the past.

- 2.5. Professor Schioldann saw Mrs Brady on 23 April 1999. He took a thorough history, and reached a diagnosis of reactive depression. He told me that, as a precautionary measure, he prescribed Zoloft (Sertraline), in case there was some underlying endogenous depression. He described Zoloft as a relatively safe drug, but said that he would not have prescribed it if he had known that Mrs Brady was taking Sinequan as well (T 33).
- 2.6. Professor Schioldann saw Mrs Brady again on 30 April 1999, when he noted that her mental state had improved.
- 2.7. On 13 May 1999 Mrs Brady saw Dr Sergeant, who gave her another prescription for Sinequan. She knew that Mrs Brady was to see Professor Schioldann on 21 May 1999, but did not advise Professor Schioldann of her

prescription. She said that she expected Mrs Brady to tell him at the next consultation (T12). She pointed out that Mrs Brady had always been a reliable historian in the past.

- 2.8. On 26 May 1999, Professor Schioldann saw Mrs Brady again. He wrote to Dr Sergeant following this consultation, thanking her for the referral. He outlined his findings, and advised that he had 'started her on a course of Zoloft 50mg daily' (the letter forms part of Exhibit C5a, Dr Sergeant's records). He explained that he considered Zoloft to be safe, in case Mrs Brady had an underlying, undiagnosed, endogenous depression (T38).
- 2.9. Dr Sergeant told me that she would not have continued to prescribe Sinequan if she knew that Professor Schioldann had prescribed Zoloft (T17). She said that she may not have seen Professor Schioldann's letter, since it carries the initials of other doctors at the clinic, but not hers. She also pointed out that Mrs Brady was next seen by Dr Carter, one of her colleagues, as she was away on holidays (T13).
- 2.10. Dr Carter saw Mrs Brady on 4 June 1999 and gave her a repeat prescription for Mogadon. Dr Carter made an entry in the casenotes that Mrs Brady had started taking Zoloft.
- 2.11. Professor Schioldann saw Mrs Brady again on 16 June 1999 and he found that she was 'euthymic' (normal mood) and optimistic for the future. He wrote again to Dr Sergeant, advising that Mrs Brady currently felt 'fully remitted'. He advised that she had been compliant with Zoloft 50mg daily, and that he would review her again in a month (Exhibit C5a). Dr Sergeant's initials appear on this letter.
- 2.12. Professor Schioldann saw Mrs Brady again on 1 July and 4 August 1999 and Dr Carter on 4 September and 22 October 1999, at which appointments her general health was monitored, and repeat prescriptions for medication, including Mogadon (Nitrazepam) but not including Sinequan, were given.
- 2.13. Mrs Brady continued to see Professor Schioldann throughout the same period, on 14 July, 11 August (on the telephone), 8 September, 29 September and 24 November 1999. He found that she was generally well, and her mood euthymic. At no stage did he consider that she was at risk of suicide (T41).

- 2.14. On 9 December 1999 Mrs Brady saw Dr Sergeant complaining of exhaustion which Dr Sergeant thought was 'post viral fatigue'. At Mrs Brady's request, she gave her a further prescription for Sinequan. She did not check with, or even advise, Professor Schioldann before doing so. She said she believed at that stage that Mrs Brady was no longer seeing Dr Schioldann (T18), although she could not point to any correspondence between herself and Dr Schioldann which would have indicated that.
- 2.15. Dr Sergeant saw Mrs Brady again on 29 December 1999, and had a 'long talk' with her about relationship problems. She said that, although she was upset, Mrs Brady did not seem clinically depressed at that time.
- 2.16. Professor Schioldann saw Mrs Brady on 5 January 2000 when he again found her mood euthymic, she was attending the gym and seemed generally happy. He noted that she should be reviewed in six weeks, and that she should continue with Zoloft, 50mg daily, in the meantime. Mrs Brady gave Professor Schioldann no indication at that time that she was contemplating suicide (T46). This is the last occasion on which Mrs Brady apparently saw a doctor prior to her death.

3. Issues arising at the inquest

- 3.1. Dr Sergeant acknowledged during the inquest that it was inappropriate that she gave Mrs Brady a prescription for Sinequan on 9 December 1999 when she was still receiving Zoloft from Professor Schioldann (T19). She said that she would not have deliberately done so, and that Mrs Brady must have told her that she had finished with Professor Schioldann (T20). Dr Sergeant did not make any note of this at the time, and her conclusions is merely a reconstruction of the events (T15, T18). I do not accept it. I find that she should not have reached that conclusion without at least checking with Professor Schioldann. Having referred Mrs Brady to Professor Schioldann for specialist treatment, it was inappropriate that she continued to prescribe psychotropic drugs without at least consulting him.
- 3.2. Professor Schioldann pointed out that the dosage of Sinequan (25mg a day) was not sufficient to constitute an anti-depressant dose, and would merely

have helped Mrs Brady sleep. He said that an adult person requires 75-100 mgs per night to achieve an anti-depressant effect (T35).

3.3. Dr Sergeant, on the other hand, prescribed Sinequan as an anti-depressant (T7), which suggests that she did not have an adequate knowledge of the properties of the medication in any event.

3.4. Professor Schioldann pointed out that it has not been demonstrated that Zoloft will potentiate the effects of Sinequan (T44), so apart from the remote possibility of developing a condition known as 'Serotonin Syndrome', there was no pharmacological risk associated with the combination of the two drugs.

3.5. However, I consider that the real risk in Dr Sergeant's actions lies in the fact that Mrs Brady's requests for more medication in December 1999 may have had psychiatric significance of which Professor Schioldann remained unaware. Dr Sergeant had referred Mrs Brady for specialist psychiatric treatment, and she should have at least consulted with Professor Schioldann before prescribing a further psychotropic drug.

3.6. Conclusion

It is not possible to conclude that the outcome would have been any different if Dr Sergeant had advised Professor Schioldann of Mrs Brady's further request for Sinequan in December 1999, since suicide is obviously unpredictable. It seems clear that Mrs Brady had been 'stockpiling' both Mogadon and Sinequan for some time, and deliberately took an overdose. Experience shows that such planning and secretiveness is difficult to detect, and Professor Schioldann certainly noticed no signs of suicidality on 5 January 2000. Whether he would have been more alerted to suicidal ideation if he had known about the further request for Sinequan remains speculation.

3.7. However, I consider that proper practice should have driven Dr Sergeant to advise Professor Schioldann that Mrs Brady had been seeking further anti-depressant medication. If she had done so, Professor Schioldann may have been given cause to reconsider his observation, on 5 January 2000, that Mrs Brady remained euthymic and a low suicide risk.

4. **Recommendations**

- 4.1. Pursuant to Section 25(2) of the Coroner's Act 1975, I recommend that General Medical Practitioners be reminded that, when a patient has been referred to a specialist, it is necessary to communicate clearly with that specialist before prescribing medication or providing other forms of treatment which may be relevant to treatment being provided by the specialist.
- 4.2. In particular, it is not enough to assume that the patient will provide the specialist with all relevant information, particularly where the patient is, or may be, suffering from a psychiatric illness.
- 4.3. Specifically, Dr Sergeant should review her clinical practices with these issues in mind.

Key Words: Suicide; drug overdose; psychiatric treatment

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 16th day of July, 2001.

.....
Coroner

Inq.No. 13/01