CORONERS ACT, 1975 AS AMENDED

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 26th and 27th days of March 2002 and the 23rd day of May 2002, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Kathleen Felicity Dann.

I, the said Coroner, find that, Kathleen Felicity Dann aged 38 years, late of 2/17 Gurner Terrace, Grange, South Australia died at Kilburn, South Australia on the 17th day of March 2000 as a result of mixed drug toxicity.

1. Background

1.1. Kathleen Felicity Dann was born on 25 March 1961. She died on 17 March 2000, eight days before her 39th birthday.

1.2. Ms Dann had been a user of heroin, and a bewildering variety of other drugs, for a long time.

1.3. For a period of about five years before her death, Ms Dann was the girlfriend of Byron Hollow, who was also a heroin addict and abuser of prescription drugs.

1.4. On 16 May 1996 Ms Dann first consulted Dr Richard Turner, a General Practitioner with a particular interest in drug dependence. Dr Turner noted that she had been using heroin at the rate of about two injections per day worth approximately $50 each. She had also been abusing Rohypnol and Valium on a daily basis. The quantities involved indicated that she was dependent upon benzodiazepines as well as heroin.

1.5. Dr Turner continued to see Ms Dann on a regular basis (three to five times per month) for the next four years.

1.6. By 1999 Dr Turner was still prescribing diazepam, temazepam and oxazepam.

1.7. In addition to these medications, Dr Turner was aware that Ms Dann continued to use heroin. Indeed, he told Detective Senior Constable Brown, who investigated this matter, that it was reasonably clear to him that Ms Dann continued to use heroin throughout this period (Exhibit C19c, p4).

1.8. Dr Turner asserted that Ms Dann's benzodiazepine dependency was a 'minimal problem', and that it tended to lessen her propensity to use heroin (Exhibit C19c, p5).

1.9. Dr Turner attempted to reduce Ms Dann's use of benzodiazepines by discontinuing the prescription of temazepam from November 1999, and suggesting that she undertake yoga to deal with her anxiety (Exhibit C19c, p7). This attempt was unsuccessful. He continued to prescribe oxazepam instead.

1.10. In addition to benzodiazepines, Dr Turner also prescribed Prothiaden (dothiepin), a tricyclic antidepressant. Dr Turner said that although Ms Dann did not suffer from depression, he prescribed Prothiaden for irritable bowel and bloating (Exhibit C19c, p7).

1.11. Dr Turner continued to prescribe Prothiaden at the same time the benzodiazepines were prescribed (see his casenotes, Exhibit C19b).

2. Events of 17 March 2000

2.1. On 17 March 2000, Ms Dann and Mr Hollow attended upon Dr Turner and he prescribed Valium, Serepax and Prothiaden to both of them, according to Mr Hollow (Exhibit C5a, p2).

2.2. Mr Hollow and Ms Dann went across the road to McDonald's and, with Coca Cola, he swallowed seven Valium tablets, five Serepax tablets and three Prothiaden tablets, and Ms Dann took seven Valium tablets, five Serepax tablets and about five Prothiaden tablets (Exhibit C5a, p3).

2.3. Ms Dann and Mr Hollow then took a bus to Kilburn and walked to the Kilburn Football Oval. Ms Dann went to a house in Florence Avenue, and after 15 minutes returned with heroin. They mixed the heroin with water, heated it in a spoon and filtered it through a cigarette butt into a syringe.

2.4. Both Ms Dann and Mr Hollow then injected themselves with heroin, after which Mr Hollow has no memory until he woke up some time later. He said:

> 'When I came to I saw Kate lying about one and a half metres from me. I think I was unconscious for about 4 hours. I took one look at her face and I could see that her lips were a purple colour. I immediately went over to her and roller her over on her side in the recovery position.
>
> I opened her mouth with my hand and vomit came out on to the ground. I then gave her mouth to mouth resuscitation. I continued resuscitation for about two to three minutes. I was not getting any response so I ran to a public phone on the other side of the football oval. I call for an ambulance by dialling triple "0".
>
> I spoke to a female person and I said to her to the best of my knowledge, "there is a person who has overdosed on heroin. Could you please send an ambulance with Narcan." I then told her the address and I went back to where Kate was.
>
> I continued to give Kate mouth to mouth resuscitation for about a minute or so and also gave cardiac massage for about 30 seconds. Then the ambulance arrived. I waved to the ambulance and they stopped on the road. Two male ambulance persons came over.'
>
> (Exhibit C5a, p4)

2.5. The ambulance arrived at about 3:56pm and, after making attempts to resuscitate her, the Paramedics pronounced Ms Dann's life extinct at 4:16pm (Exhibit C6a, p2).

3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 20 March 2000. Dr Gilbert determined that the cause of Ms Dann's death was 'mixed drug toxicity'.

3.2. A toxicological analysis disclosed that Ms Dann's blood contained:

> '**RESULTS:**
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> 1. The blood contained:
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> | | | |
> |---|---|---|
> | (1) | 2.6 mg dothiepin per litre. | (fatal level) |
> | (2) | 0.31 mg morphine per litre. | (potentially fatal level) |
> | (3) | 0.55 mg nordiazepam per litre. | (non-toxic/therapeutic) |
> | (4) | 0.50 diazepam per litre. | (non-toxic/therapeutic) |
> | (5) | approximately 1.0 mg oxazepam per litre. | (non-toxic/therapeutic) |
> | (6) | approximately 0.05 mg codeine per litre. | (non-toxic/therapeutic) |
>
> 2. The urine contained:
>
> (1) morphine and codeine
>
> (Exhibit C4a, p1)

3.3. The Toxicologist did not detect monoacetylmorphine, alcohol or methadone in the blood (Exhibit C4a).

3.4. Dr Gilbert commented:

> '**COMMENTS:**
>
> 1. Death was due to mixed drug toxicity. The blood contained a lethal level of the tricyclic antidepressant dothiepin, a high, potentially lethal level of morphine and therapeutic levels of diazepam, oxazepam and codeine. Codeine is a common contaminant in street heroin. The morphine in the blood was presumably administered intravenously in the form of heroin. This was not confirmed by the finding of monoacetylmorphine in the urine indicating that the deceased must have succumbed quickly assuming that she injected heroin shortly before her death. The available history gives no indication of the source of the dothiepin or the reason for taking it.
>
>   The deceased's father believed that she was taking naltrexone. The results of the analysis for naltrexone were not to hand at the time of this report.
> 2. Analysis of a specimen of blood obtained at autopsy reportedly showed a blood alcohol concentration of nil.
> 3. There were no injuries or other markings on the body to indicate the involvement of another person in the death.
> 4. No natural disease that could have caused or contributed to the death was identified at autopsy.
>
> (Exhibit C3a, p4-5)

3.5. In relation to Dr Gilbert's reference to naltrexone, a further toxicological analysis disclosed that neither naltrexone nor its major metabolite 6-beta-naltrexol were detected in the blood (Exhibit C17a). If Ms Dann had been taking naltrexone, her tolerance to heroin may have been reduced, but this was not so.

3.6. Assessment of medical treatment

3.7. I heard evidence from Dr Robert Ali who is the Director, Clinical Policy and Research at the Drug and Alcohol Services Council, an incorporated unit of the South Australian Health Commission. Dr Ali has very broad experience of issues relating to alcohol and drug related problems, and has been extensively involved in developing policies and clinical practices in relation to treatments involving methadone.

3.8. Dr Ali confirmed that when Dr Turner first saw Ms Dann in May 1996, the amount of Rohypnol and Valium she was using on a daily basis, the equivalent of 90 to 130mg

of diazepam per day, indicated that she was physically dependent on these substances in addition to her heroin dependence.

3.9. Notwithstanding this dependence, Dr Turner appears to have made no attempt to reduce the rate of her benzodiazepine intake and indeed, Dr Ali said that the quantities he prescribed to her over the years were sufficient to have 'maintained the benzodiazepine dependency' (Exhibit C21b, p1).

3.10. Dr Ali queried Dr Turner's prescription of multiple types of benzodiazepines rather than prescribing a single long-acting benzodiazepine, namely diazepam, in order to try and modify and reduce her intake.

3.11. Dr Ali was surprised that Dr Turner did not suggest that Ms Dann should recommence methadone maintenance treatment in view of the fact that he knew that she had relapsed back to heroin use.

3.12. Further, Dr Ali was concerned that Dr Turner continued to prescribe Prothiaden, which is a tricyclic antidepressant, in addition to the benzodiazepines and in the knowledge that she was also taking heroin. He said:

> 'The need to closely monitor the use of tricyclic antidepressants such as Prothiaden in combination with benzodiazepines for people who continue to use heroin is a major issue. The ability of these drugs to interact and depress central nervous function, particularly respiratory drive, is a crucial issue that requires close surveillance. I am not aware of any scientific evidence to support the view that routine prescribing of benzodiazepines will diminish cravings and impulsivity associated with heroin use.'
>
> (Exhibit C21b, p2)

3.13. Dr Ali suggested that Dr Turner should have sought advice from colleagues on the care of Ms Dann, and should have considered referring her back to Waranilla for ongoing management of her poly-substance abuse. He described the continuance of prescriptions of benzodiazepines and tricyclic antidepressants in the knowledge that she continued to use heroin as a 'risky approach' (Exhibit C21b, p2). He said:

> 'Minimising this risk can occur through supervised outpatient daily dosing and limiting the prescribing doctors to one individual doctor who can closely monitor and supervise the patient's progress.'
>
> (Exhibit C21b, p2)

3.14. Dr Turner asserted that he did not take any steps towards Ms Dann recommencing the methadone maintenance program because she denied that she was using heroin (T32).

The objective evidence, however, is that there were several entries in his casenotes which indicated that she was still using heroin. For example, on 8 February 1999 a discharge summary from the Royal Adelaide Hospital indicated that she was still using heroin. The fact that Ms Dann continued to associate with Mr Hollow, and was still very much involved in the drug scene meant that there was always a likelihood that she would continue to use heroin. (T36).

3.15. Dr Turner accepted that Ms Dann was dependent upon benzodiazepines and that he did not try to modify that dependency, saying that since her death he has now changed his approach (T39). He accepted that prescribing multiple benzodiazepines with Prothiaden, in the knowledge that she may still be taking heroin, was a risky approach, saying he did so to maintain a therapeutic relationship with his client. He said:

> 'Yes, it's partially in response to the request of the patient and what they're habituated to in that situation and people will still be coming to me now that there's been a squeeze-down on switching from capsules of Temazepam which people use for injecting to the tablets, saying that the Temazepam capsules were better for them in terms of sleep and other people will say Oxazepam or the Serepax work better and the Diazepam worked better through the day to relieve their anxiety. Yes, people do use tablets in the similar way, in my understanding in a similar way to people use cigarettes. They will use them to punctuate their day, like sitting down having a cup of tea and a Bex used to be years ago. People's behaviours and patterns, even though we think they're disastrous for them, work for them to get through their days and it's a difficult situation for medical practitioners and even the general public to be in. Sort of like a bit of a stuck situation and I suppose sometimes it's important in terms of therapy to keep up the relationship - it might be abused and the doctors be manipulated and behind their backs they might be treated like, be talked about as useless drug pusher type thing. But that's part of what goes on in prescribing from my point of view.' (T42-43)

3.16. Having heard Dr Turner's evidence, I accept that he had a very genuine concern for Ms Dann's condition, and that he adopted a rather passive approach to her continued poly-substance abuse on the basis that he might be able to minimise the harm she was doing to herself through ongoing counselling and education.

3.17. While Dr Ali accepted that Dr Turner had this genuine concern, he doubted that there was any point in maintaining a therapeutic relationship if the relationship was not proving therapeutic. He said:

> ' It's a difficult balance to try and engage a patient in therapeutic relationship where their presentation will be that they are suspicious of you. They've got a view about what they think is good treatment and they will want - and there are boundaries around what they

> will accept, so some of them are very assertive in their demands for what they see as appropriate treatment. You want those people to be looked after, but you want it to be done in a way that is actually in their interests, and the margin at where it stops being in their interests and starts being just being another source of drugs is sometimes difficult to judge, particularly for complex patients who have got very difficult social circumstances. It's easier to do for heroin treatment because there are legal requirements that you have to - you have to ask questions, and you have to do things to get authorisation to be a prescriber but, having said that, the principles for treating Benzodiazepine addiction aren't any different, and the concern that I would have would be about the locus of control - that if you're not in an arrangement where you're exercising judgment in their interest – if they're exercising all the judgment and you feel you're just passive, and if you don't do what they want they will go somewhere else - I think you've lost your therapeutic advantage. You're no longer providing them with a reflection on reality. I think your assessment about Dr Turner is quite right. I think he does genuinely have his patients' interests at heart and he is trying to do what he believes to be in their interests. There are components of his practice that, philosophically, I don't agree with but, from a practice management point of view, I would say, 'Well, I just don't think that's good practice'. Not everybody will want to come to our drug treatment program, and the fact that the majority of heroin users are treated in private practice is an indication of the fact that they would be preferred to be treated in the private sector - and they can be managed safely and effectively, but that doesn't mean that everything they want, you do.' (T95-96)

4. Conclusions

4.1. Ms Dann was a ‘poly-substance abuser’ who had been consulting Dr Turner since 1996. During that time he had continued to prescribe benzodiazepines to her at a high rate, and did not do anything effective to reduce her dependence on them.

4.2. Additionally, Dr Turner prescribed Prothiaden, a tricyclic anti-depressant, in circumstances where he knew there was a substantial likelihood that she was continuing to use heroin.

4.3. Dr Ali described Dr Turner’s approach as ‘risky’ and I accept his evidence about that, as did Dr Turner. My conclusion is that Dr Turner’s treatment approach to Ms Dann was unduly passive.

4.4. It was motivated by genuine concern for her welfare, but it did not provide any therapy to her. Dr Turner failed to maintain what Dr Ali described as his ‘therapeutic advantage’ with his patient.

4.5. The circumstances of Ms Dann’s death, the manner in which she and her boyfriend collected the prescription from Dr Turner, collected her drugs from the pharmacy,

consumed an enormous quantity of them at once, and then went and injected heroin, demonstrate how anti-therapeutically the drugs were being used.

5. Recommendations

5.1. Dr Turner told me that he no longer accepts the rather idiosyncratic view that ongoing benzodiazepine abuse, particularly by a poly-substance abuser, is to be tolerated as a minor issue. He has already reviewed his clinical approach in this regard.

5.2. It seem to me that Ms Dann presented a complex and challenging set of problems for Dr Turner, and he might have been better advised to refer her back to a more specialised treatment centre, such as Warinilla, rather than continuing to try and manage her.

5.3. Obviously, the ultimate responsibility for Ms Dann's behaviour rested with her, and Dr Turner could not force her to do things she did not want to do. However, he should continue to review his therapeutic approach to such patients, with a view to deciding whether it is desirable in the patient's interest to maintain a 'therapeutic relationship' if it is no longer therapeutic.

Key Words: Drug Overdose; Heroin; Benzodiazepine Dependency; Medical Treatment

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 23rd day of May, 2002.

Coroner