

*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 6<sup>th</sup> and 7<sup>th</sup> days of May and the 11<sup>th</sup> day of July 2002, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Yutta Elise Taylor.*

*I, the said Coroner, find that, Yutta Elise Taylor aged 47 years, late of 21 Victor Avenue, Woodville West, South Australia died at Woodville West, South Australia on the 18<sup>th</sup> day of July 2000 as a result of serotonin syndrome due to combined toxicity of moclobemide and paroxetine.*

### **1. Introduction**

- 1.1. Mrs Yutta Taylor was a 47 year old woman who lived with her husband at Woodville West.
- 1.2. During the evening of 17/18 July 2000 Mrs Taylor complained to her husband of urinary frequency and lower abdominal pains. He called a locum service and Dr Fermo Dottore attended at about 1am on 18 July.
- 1.3. Dr Dottore examined Mrs Taylor and found tenderness in the lower abdomen consistent with a urinary tract infection. He prescribed Augmentin Duo Forte, an antibiotic. He said:

'From my observations, I found that Taylor appeared normal, pleasant, cooperative and not distressed ... from my conversation with Taylor at the time, I established that she had no allergies and that the only medication she was taking was HRT (Hormone Replacement Therapy). I am not aware of her medical history and this was the first time I came into contact with her.'

(Exhibit C6a, p2)

- 1.4. Mr Taylor said that about 8:10am on 18 July 2000 his wife appeared very hot. He checked her temperature and it was 38.7°. He noticed that she had begun taking quick short breaths through her mouth. She refused to go to hospital (Exhibit C1a, p2).
- 1.5. At about 8:20am Mr Taylor returned to the bedroom and found that his wife was very hot to touch, did not appear to be breathing, and was unresponsive. He called an ambulance which attended but Mrs Taylor could not be revived. Mr Lars Richter, a Paramedic with South Australian Ambulance Services, examined Mrs Taylor at 8:40am on 18 July 2000, found that there were no heartbeats, respiration or pulse, and that the pupils were fixed and dilated. He pronounced life extinct at that time (Exhibit C2).

## 2. **Cause of death**

- 2.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 19 July 2000. Dr Gilbert concluded that the cause of death was 'serotonin syndrome due to combined toxicity of moclobemide and paroxetine'. He commented:

1. The police investigation indicated that the deceased had received prescriptions for both moclobemide (antidepressant of reversible monoamine oxidase inhibitor type, trade name Aurorix) and paroxetine (antidepressant of selective serotonin re-uptake inhibitor type, trade name Aropax) on 17/7/2000, the day before death. Examination of the packages indicated consumption of 10 paroxetine tablets and 12 moclobemide tablets between the time of dispensing and death, a period of less than 24 hours. An empty packet of 30 paroxetine tablets dispensed on 8/7/2000 was found in a garbage bin further suggesting excessive consumption of paroxetine.

Toxicological examination of a specimen of blood obtained at autopsy showed a 'lethal' concentration of moclobemide and a toxic concentration of paroxetine.

Excessive consumption of either drug in isolation was unlikely to cause serious problems but the combination of the two, even at therapeutic doses, produced a predictable and potentially lethal interaction referred to as the serotonin syndrome. Symptoms of serotonin syndrome include:

- a. Mental/behavioural changes including agitation, restlessness, confusion, incoordination, hypomania, coma and possibly seizures.
- b. Altered muscle tone and neuromuscular activity including myoclonus, hyperreflexia, shivering, rigidity and tremor.
- c. Autonomic instability including hypertension or hypotension, tachycardia and profuse sweating, hyperpyrexia and diarrhoea.

The deceased's reported symptoms of facial flushing, sweating, fever and abdominal pain could be accounted for by the serotonin syndrome.

2. A locum doctor saw the deceased in the early hours of the morning of her death and diagnosed a urinary tract infection on the basis of lower abdominal pain and tenderness, 'burning of urine' and urinary frequency. He recorded her prescribed medications as hormone replacement therapy only and elicited bladder tenderness. The provisional diagnosis was a 'likely urinary tract infection' and antibiotics were prescribed. This diagnosis was understandable if the locum was completely unaware of the deceased's previous history of overdoses and recent prescriptions for two incompatible antidepressants.

Prescriptions for Aurorix and Aropax from different doctors were submitted together to a pharmacist by the deceased on the day before death (17/7/2000). The interaction between these two incompatible drugs should be well known to dispensing pharmacists. It would have been prudent for the pharmacist to have contacted one or both prescribing doctors and determine if it was intended that she take this combination.

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)

- 2.2. The details of the toxicological analysis were as follows:

1. The blood contained:

- (1) 21mg moclobemide per L. (lethal concentration)
- (2) 1.8mg presumptive paroxetine per L. (toxic concentration)

2. Neither alcohol or valproic acid was detected in the blood. '

(Exhibit C5a)

### 3. **Background**

- 3.1. It would seem from the evidence that Mrs Taylor had been an abuser of prescription drugs for a considerable period of time. Records from the Modbury Public Hospital indicate that, as far back as June 1992, Mrs Taylor was admitted to hospital unconscious, after having been found unrousable in bed by her husband. It subsequently transpired that she had attended a General Practitioner, pretended that she had come from Queensland, that she was a diabetic, that she had lost her prescription for insulin, and received a prescription for insulin. She then administered the drug to herself and suffered an overdose.

3.2. It would seem that Mrs Taylor sustained some organic brain damage as a result of this episode, although the extent of that damage has not been determined with any precision.

3.3. Mrs Taylor's clinical condition gradually improved while she was in Modbury Hospital and later at the Julia Farr Centre. By the time she was discharged from Julia Farr, on 4 August 1992, her neurological state had improved to the extent that the Registrar was able to comment:

'Probably will improve but is likely to have long standing short term memory deficit. Will need to determine husband's ability to manage with her at home and determine her independence level. May need Community Services Incorporated support.'

(Exhibit C18)

3.4. Mrs Taylor was seen by Dr Paul Dignam, Director of Psychiatry at Modbury Hospital, in October 1993. Dr Dignam suspected that Mrs Taylor may have suffered from hypomania prior to the insulin overdose in 1992. He said:

'The nature of her function since the overdose is difficult to define. She seems to have residual problems with concentration, memory and judgment although these are not grossly apparent in an interview. I found it difficult to determine whether she had become depressed or merely apathetic (frontal lobe) following the brain damage but a conversation with her GP, Dr Cawley, today suggests that she had indeed been profoundly depressed with sleep disturbance and a marked loss of confidence and the introduction of fluoxetine had produced some definite improvement.

Mrs Taylor was unable to explain her overdose but conversation with her husband and GP suggests that these are usually impulsive, taken to relieve current symptoms and often forgotten immediately afterwards. They do not seem to be an indication of depressive illness per se.'

Later in his report, Dr Dignam said:

'She has, in addition, substantial problems with cognitive impairment which are much more marked than her social veneer would lead you to believe ... close supervision of her medication appears to be the critical variable and she will inevitably slip through from time to time.'

(Dr Dignam's report is contained in the Modbury Hospital casenotes, Exhibit C15)

3.5. The Modbury Hospital casenotes record that, as Dr Dignam predicted, there were a number of further episodes of overdose of prescription drugs. In January 1994 Mrs Taylor overdosed with Serepax, in July 1995 with Prothiaden, in November 1995 with Lithium, and in August 1997 with Beta blockers. Mr Taylor recalled that his wife had

attempted to overdose about three months before she died, in July 2000 (Exhibit C1a, p3).

#### **4. Recent medical history**

- 4.1. Detective Senior Constable Peter Dietmann of Port Adelaide Investigations, seized the casenotes of Dr Brian Butcher by Coroner's Warrant. I was informed that Dr Butcher is suffering from a terminal illness and was unable to assist the inquiry. The notes (Exhibit C16) disclosed that Mrs Taylor attended upon Dr Butcher on 30 January 2000 and he prescribed Aropax (20mg x 1 tablet in the morning). Aropax is the trade name for paroxetine, an antidepressant medication of the selective serotonin re-uptake inhibitor (SSRI) type.
- 4.2. Mrs Taylor consulted Dr Butcher on several further occasions, but the records do not suggest that he prescribed any further antidepressants for her. On 16 February 2000 he advised her to increase the dose to two tablets in the morning after food (Exhibit C11a, p3).
- 4.3. Mrs Taylor failed to keep an appointment with Dr Butcher on 24 March 2000. She began consulting Dr Hariklia Tsokkos at her surgery at Findon Road, Findon. She first saw Dr Tsokkos on 6 March 2000, the day after she last saw Dr Butcher.
- 4.4. Dr Tsokkos said that Mrs Taylor presented with depression and anxiety for which she was taking Aropax, Xanax and Serepax. She was complaining of migraine headaches and a swelling of the neck. Dr Tsokkos said that she requested a copy of Dr Butcher's file but did not receive anything from his practice.
- 4.5. Dr Tsokkos did not notice any sign of cognitive deficit, nor any sign of other neurological symptoms (T16-17). She said that Mrs Taylor told her of her husband's manic depression, and her main problem seemed to be coping with his illness. She was very anxious and the level of her mood depended upon his condition (T18).
- 4.6. Dr Tsokkos saw Mrs Taylor on 10 March 2000 when she was still complaining of headaches.
- 4.7. On 22 March 2000, Mrs Taylor told Dr Tsokkos that her husband was in hospital and that she was 'very stressed'. Dr Tsokkos said that the Aropax she had received from Dr Butcher was not helping so she changed her medication to Aurorix 300mg twice

daily. Aurorix is the brand name for moclobemide, and is an antidepressant of the reversible monoamine oxidase inhibitor (MAOI) type. Dr Tsokkos gave Mrs Taylor a prescription for Aurorix with five repeats (Exhibit C11b) which was six months worth of medication.

- 4.8. Dr Tsokkos said that she was aware of the need to discontinue taking Aropax for at least three days to allow it to 'wash out' of the system before commencing on Aurorix, because the two medications can cause problems in combination, and she advised Mrs Taylor accordingly. She said that Mrs Taylor appeared to understand her advice (T21).
- 4.9. On 31 March 2000 Mrs Taylor requested more Xanax (a benzodiazepine) tablets. Dr Tsokkos checked with the Health Insurance Commission, and was advised that Mrs Taylor had already received 600 tablets since January 2000 from another prescriber. She told Dr Tsokkos that she had thrown some of them out. Dr Tsokkos gave her a prescription for 50 more Xanax tablets while strongly advising her to reduce her intake, and that she would not prescribe any more for at least a month (Exhibit C12, p3).
- 4.10. Dr Tsokkos saw Mrs Taylor again on 4 April 2000 but did not prescribe anything further.
- 4.11. On 7 April 2000 Mrs Taylor told Dr Tsokkos that she was 'still very stressed and not sleeping well'. She prescribed Normison and Diazepam but no further Aurorix.
- 4.12. On 11 April Dr Tsokkos saw Mrs Taylor again. Mrs Taylor's mood had lifted because her husband had been discharged from hospital. Dr Tsokkos told her to increase the Aurorix from one tablet twice daily to one and a half tablets twice daily. It is not clear why this increase was considered necessary.
- 4.13. Dr Tsokkos saw Mrs Taylor on 12 April 2000 when she presented with a possible urinary tract infection. No antidepressant medication was prescribed on that day.
- 4.14. On 27 April 2000 Mrs Taylor consulted Dr Tsokkos' partner, Dr Bill Tolis. Dr Tolis' statement (Exhibit C17) contains the following passage:

I was aware from the notes that she had already been prescribed Aurorix 300mg by Dr Tsokkos. From the Health Insurance Commission report dated 28 March 2000 it

appeared that she was not taking the Aurorix tablets prescribed to her by Dr Tsokkos on 22 March 2000. I decided to switch her from Aurorix to Aropax because it is considered to be the drug of choice for anxiety disorders. I explained to Yutta the possible side effects and that it was not to be taken with the Dothiepin she had previously prescribed. I do not recall having any conversation with her about taking the previously prescribed Aurorix tablets with Aropax tablets.' (p2)

- 4.15. Dr Tolis formed the opinion that Mrs Taylor was non-compliant with taking Aurorix, and that she was more interested in taking benzodiazepines. He also concluded that she was a 'doctor shopper'. He had no evidence for either conclusion. He volunteered that 'she struck me as that sort of personality' (T116).
- 4.16. Dr Tolis told me that he clearly remembered Mrs Taylor telling him that Aurorix was not effective for her. He concluded from that statement that she was not taking it (T121).
- 4.17. On the basis of that conclusion, Dr Tolis did not warn Mrs Taylor about taking Aropax and Aurorix together (T123).
- 4.18. Dr Tolis told me that he regarded Mrs Taylor's complaints as merely a 'front' for obtaining benzodiazepines. He seems to have reached that conclusion on the basis of supposition, and not evidence. He gave her statements to him about the usefulness of Aurorix no credence at all.
- 4.19. Dr Tsokkos told me that it was her opinion that Aurorix was better for anxiety. She said:

'I thought the Aurorix may help more with the anxiety and agitation she was experiencing.'

(Exhibit C12, p3)

Dr Tolis said the reverse:

'I decided to switch her from Aurorix to Aropax because it is considered to be the drug of choice for anxiety disorders.'

(Exhibit C17, p2)

Neither doctor seems to have discussed this issue with the other one before switching medications. This lack of consultation seems surprising among partners in a general practice making such a significant change to a patient's medication.

- 4.20. Dr Tolis saw Mrs Taylor again on 26 May 2000 for an unrelated condition. He repeated her prescription for Temazepam and Xanax because 'she told me that she had been taking them and it appeared to me that she had been using those drugs appropriately' (Exhibit C17, p3). This contradicts his oral evidence about Mrs Taylor's addiction to benzodiazepines (T127).
- 4.21. Mrs Taylor saw Dr Tsokkos on 6 June 2000 and received more Diazepam. She was complaining of epigastric pain.
- 4.22. On 20 June 2000 Mrs Taylor consulted Dr Tolis for an unrelated matter. He gave her more Diazepam.
- 4.23. On 27 June 2000 Dr Tsokkos saw Mrs Taylor again. She was still concerned about her husband's condition and said that she was 'feeling sick and depressed, not sleeping and not coping'. Dr Tsokkos gave another prescription for Aropax (20mg daily). Dr Tsokkos accepted that Dr Tolis had changed the medication back to Aropax and I accept that it was appropriate to continue that prescription, rather than switching back again.
- 4.24. Dr Tsokkos saw Mrs Taylor on 28 June 2000 at home when she visited her husband, and again on 10 July 2000 when she reviewed her husband. On both occasions she thought that Mrs Taylor seemed a lot better.
- 4.25. Both Dr Tsokkos and Dr Tolis said they saw no signs of cognitive deficit or other neurological symptoms, nor did they have any concern that Mrs Taylor was suicidal. I accept their evidence about that. It is consistent with her earlier presentations, going right back to Dr Dignam's comments in 1993.
- 4.26. I must say that I have less difficulty accepting the evidence of Dr Tsokkos, who presented as a careful and caring practitioner, than I do with the evidence of Dr Tolis. Dr Tsokkos was obviously junior to Dr Tolis in the practice, and appeared to defer to him. Unfortunately, Dr Tolis gave the impression of a rather opinionated man, who jumped to the opinion that Mrs Taylor was a 'doctor shopper' and 'benzo seeker' who was not interested in helping herself. His attitude can be illustrated by

quoting the following passage from the evidence:

' Q. If you suspected that she was a Benzodiazepine seeker wouldn't you want to see the previous casenotes to see whether your suspicion about that was confirmed.

A. If I suspected that she was a Benzo seeker would I want to see the casenotes. Personally no, because I'm not interested in that sort of patient.

Q. Is that to say you weren't interested in her.

A. Pardon?

Q. Is that to say you weren't interested in Ms Taylor.

A. There is little joy gained in trying to help people such as this, so it's really left up to GPs that have more patience or more interest in this sort of area, with people with these sort of particular problems. If in doctor/patient relationship the trust isn't there and especially for doctors easily available in coming to see you then perhaps they shouldn't.'

(T140)

In view of that opinion, it is unfortunate that Dr Tolis did not refer Mrs Taylor to another practitioner, rather than continuing to see her, and to change her medication.

- 4.27. In those circumstances, I conclude that Dr Tolis' failure to warn Mrs Taylor about the dangers of taking Aropax and Aurorix together was not justified on the basis that she had discontinued taking Aurorix. There was no basis for that conclusion. One can only speculate what the real reason may have been.

## 5. **Dispensation of medication**

- 5.1. I heard evidence from Ms Catherine Caird, a Registered Pharmacist and partner in the business known as the Colin Johns Chemist in Findon Road at Findon, virtually across the road from the surgery of Drs Tsokkos and Tolis. Ms Caird said that she could recall seeing Mrs Taylor on a number of occasions.

- 5.2. Ms Caird first met Mrs Taylor on 10 March 2000 when she dispensed benzodiazepines for anxiety, but not Aropax. Ms Caird said that she spoke to Mrs Taylor on that day and learned that her husband was chronically unwell and that she was having trouble dealing with that issue (T64). Her impression was that Mrs Taylor was an intelligent, lucid and well presented woman (again consistent with Dr Dignam's comments in 1993).

- 5.3. At this point, it is convenient to set out in table form the occasions on which Aropax and/or Aurorix were dispensed to Mrs Taylor at the Colin Johns Chemist, when they were dispensed, by whom and on whose prescription. That information is as follows:

<i>Date Dispensed</i>	<i>Medication Prescribed</i>	<i>Dispensed By</i>	<i>Prescribed By</i>	<i>Date Prescribed</i>
22 March 2000	60 x Aurorix 300mg	C Johns	Dr Tsokkos	22 March 2000
11 April 2000	60 x Aurorix 300mg	M Fietz	Dr Tsokkos	11 April 2000
27 April 2000	30 x Aropax 20mg	M Fietz	Dr Tolis	27 April 2000
16 May 2000	60 x Aurorix 300mg	C Johns	Dr Tsokkos	22 March 2000 or 11 April 2000
27 June 2000	30 x Aropax 20mg	C Johns	Dr Tsokkos	27 June 2000
8 July 2000	30 x Aropax 20mg	M Fietz	Dr Butcher	30 January 2000
17 July 2000	30 x Aropax 20mg	C Caird	Dr Butcher	30 January 2000
17 July 2000	60 x Aurorix 300mg	C Caird	Dr Tsokkos	22 March 2000

- 5.4. On 27 April 2000, when Dr Tolis switched Mrs Taylor from Aurorix back to Aropax, Mr Fietz made a note (Exhibit C11b) that he warned her against taking Aropax and Aurorix together.
- 5.5. On 11 April 2000 Dr Tsokkos gave Mrs Taylor another prescription for Aurorix because she told her she was running out. Dr Tsokkos said that although her memory was not good on this point, she thought Mrs Taylor must have told her that she had lost the prescription (with five repeats) which Dr Tsokkos had given her on 22 March 2000 (T48). If Mrs Taylor did say that, it was obviously untrue, since Mrs Taylor produced the 22 March 2000 prescription on 17 July 2000 to Ms Caird.
- 5.6. Clearly, the most questionable instance of dispensation of medication occurred on 17 July 2000 when Ms Caird dispensed both Aropax and Aurorix to Mrs Taylor at the same time. As the above table shows, Mrs Taylor had received a total of 90 Aropax tablets (enough for 45 days) in the space of 20 days between 27 June and 17 July, which might have led to the suspicion that Mrs Taylor was either abusing or hoarding the medication.
- 5.7. But the most worrying aspect of the dispensation was the fact that the two medications were dispensed together. Ms Caird said that she was concerned

immediately that Mrs Taylor requested both medications. She was well aware of the danger of serotonin syndrome, and raised her concerns with Mrs Taylor. She outlined their conversation as follows:

'I recall that I looked at the two prescriptions that she had given in, and to be dispensed, and I was concerned at the, the two items together, which were Aropax and Aurorix. I was concerned that she wanted to collect the two of them on that day because they should not be taken together, and I had a look at her, her history as to what she had received previously from the pharmacy, and the notes that were against her history which had, which indicated that she, a discussion had taken previously advising her not to take these two medications together. So I went and, out to discuss with her as to why when wanted to obtain the two. I expressed my concern to her that she wanted to collect the two medications. I do recall her saying that she was working – Her, her doctor was closely supervising the medication that she was taking, and that she was well aware that she shouldn't take the two together. I know the pharmacy assistant was there at that time and she, at that stage she moved away and left Ms Taylor and myself to have a private conversation. The – so we continued talking about why she wanted to collect the two medications and there was also the other issue that she had collected the Aropax from us only ten days prior, and that medication should've lasted her thirty days, I think it was. So in answer to why I, when I was asking her about collecting the Aropax, she said that she had misplaced or, or couldn't find those tablets, and she wanted to keep on taking them so she wanted another lot today. And then I asked why, why she wanted to collect the two together and I can't remember the exact words that were said, and she said that she was – I was aware she's had a history of taking both of them at different times. She said that she was thinking about going back on to the Aurorix, but at this time she wanted to stay on the Aropax. We discussed – And, and she already knew this, but we again discussed this again, that there must be an interval of three or four days between stopping one medication and starting the other. And so at the, at the end of our conversation and I, I was aware I wasn't telling her anything new. She already knew the issues with the medication, that she must not take the two together and that she must break between taking the two. We had, we had a lucid, intelligent conversation. She seemed very aware of what she was doing and I felt that she was very competent in how to take her medication.'

(Exhibit C13, p4-5)

- 5.8. The Pharmacy Assistant, Joanne Turner, corroborated, in general terms, Ms Caird's evidence. She said that Mrs Taylor seemed 'happy and cheerful', and that Ms Caird spoke to her about the prescriptions, and then about the medication after it was dispensed (Exhibit C8a, p2).
- 5.9. Ms Caird said that she considered contacting Dr Tsokkos to check Mrs Taylor's assertions, but decided not to because Mrs Taylor convinced her that she was genuine (T72).

- 5.10. Ms Caird conceded that dispensing both of these medications together was unusual, indeed she could not remember having done so before (T81).
- 5.11. In her defence, Ms Caird said that she was aware that Mrs Taylor had been warned by Mr Fietz previously about the combined effect of these two drugs, and she repeated this to Mrs Taylor on 17 July 2000. She said that Mrs Taylor appeared to fully understand what she said to her, and was 'friendly and chatty' (T71). She said that she had no suspicion that Mrs Taylor was suicidal.
- 5.12. Ms Caird said that she had no concern that different doctors had prescribed the two medications, and that the prescription for Aropax went back to Dr Butcher in January that year, because she was aware that Dr Tsokkos herself had prescribed Aropax more recently. She said the prescription remained valid for twelve months and it was not unusual to fill a six month old prescription (T77).

## **6. Expert evidence**

- 6.1. I heard evidence from Associate Professor Nick Buckley, who is the Director of Clinical Pharmacology and Toxicology at the Canberra Hospital, having recently left a similar position in Adelaide. Associate Professor Buckley is highly qualified and widely experienced in the area of drug interactions and toxicology, and he provided me with a report commenting on certain aspects of Mrs Taylor's medication (Exhibit C14).
- 6.2. Dr Buckley said that he had some concerns in relation to the toxicology report (Exhibit C5a), which described the concentration of moclobemide (Aropax) of 21mg per litre as 'lethal'. Dr Buckley said that this is by no means clear. He said that it is quite rare for an overdose of moclobemide by itself to be fatal, as indeed is an overdose of paroxetine (Aurorix) by itself (T88).
- 6.3. Dr Buckley said that it was much more likely that Mrs Taylor died as a result of a combination of the two medications. He said the two drugs potentiate each other, so that they have an effect upon the patient which is greater than the sum of their individual effects, and this almost universally leads to serotonin syndrome when the medications are taken together (T89).

6.4. Dr Buckley said that a one to two day 'washout' is sufficient, so that the advice given by Dr Tsokkos in that regard was correct (T109).

6.5. Dr Buckley said that it is clear from the toxicological analysis of Mrs Taylor's blood that she took both Aropax and Aurorix in overdose which led to her developing serotonin syndrome. He said that it is likely that Mrs Taylor's fever was much higher than the 38.7° measured by her husband, and that this may have led to death from severe hyperthermia. He said:

'Alternatively, rigidity or seizures (also from a severe serotonin syndrome) might have led to a respiratory arrest.'

(Exhibit C14, p4)

6.6. Tragically, if Mrs Taylor had been admitted to hospital at an early stage, it is likely that her condition could have been controlled in an Intensive Care Unit by controlling her body temperature (T91).

6.7. Dr Buckley said that in his experience the size of the overdoses involved in this case argue against the possibility of an accidental overdose, although Mrs Taylor's brain damage may have been a confusing factor (Exhibit C14, p4). Dr Buckley also observed that in his experience a deliberate overdose of the combination of these drugs is 'very unusual'. He added:

'The prescribed (label) doses of each antidepressant were within the recommended range. It is clear in retrospect from the frequency with which the medication was dispensed that chronic over-medication was probably occurring with paroxetine and benzodiazepines. As she was seeing multiple doctors, the pharmacist would have been in the best position to recognise this problem and the interaction. It would indeed have been prudent to contact the prescriber about such a potentially serious drug interaction. (In her defence, pharmacists sometimes get little thanks from questioning the wisdom of a doctor's prescription. Those doctors who are the worst prescribers are also the worst at taking advice.) However, if Mrs Taylor's intention to mix these two drugs in overdose was premeditated and deliberate, she could quite easily have filled the other prescription at a different time or a different pharmacy and achieved the same end.

It is reasonable to expect pharmacists and doctors to take all measures they can to prevent inadvertent drug interactions. However, it is practically impossible to completely prevent deliberate misuse of medications in this way. The very things that are usually done to prevent the former (giving advice to the patient, checking they understand, etc) may increase the potential for deliberate harm.'

(Exhibit C14, p4)

- 6.8. When Mr Abbot, Counsel for Ms Caird, pointed out that Mrs Taylor had an extensive history of overdosing, including incidents in January 1994, July 1995, August 1995, November 1995 and August 1997, Dr Buckley agreed that the conclusion that Mrs Taylor deliberately overdosed herself on or about 18 July 2000 was more easily reached (T95).
- 6.9. Dr Buckley also agreed that if Mrs Taylor intended to harm herself, in view of the fact that she had received prescriptions for both Aropax and Aurorix prior to 17 July 2000, she could have done so at any stage (T96). I accept that this point has some force.
- 6.10. As for the dispensation of the drugs, Dr Buckley said that, faced with a situation such as this, the pharmacist has only two choices - either to warn the customer, or decline to dispense the medication (T108).
- 6.11. Dr Buckley pointed out that since Mrs Taylor was producing prescriptions written several months apart for drugs with a dangerous interaction, the pharmacist was the only person with the opportunity to notice that the drugs were being dispensed together (T109).
- 6.12. In those circumstances, Ms Caird took a heavy onus upon herself when she decided to trust her impression of Mrs Taylor on 17 July 2000, rather than referring the issue to Dr Tsokkos. Ms Caird knew nothing of Mrs Taylor's medical history, and her opportunity to assess her mental state, a process for which she was not qualified in any event, was limited. Apparent cheerfulness, even euphoria, can be signs that a person has decided to end their life. I think that a pharmacist should not try and make an assessment of the suicidality of the patient, but rather should refer any case where drugs with a potentially dangerous interaction are being dispensed together to the prescribing doctor.
- 6.13. Conclusion
- I conclude that although the dispensation of both of these drugs by Ms Caird on 17 July 2000 was done in good faith, it was inappropriate in the circumstances. Although Ms Caird warned Mrs Taylor about taking the drugs in combination, this was not sufficient. She should have referred the matter to the prescribing doctor before dispensing the two drugs together. There is no guarantee that the outcome would have been different, but if the inquiry had been directed to Dr Tsokkos, there is

a chance that she would have recognised the riskiness of dispensing the drugs together, and this may have avoided the tragic outcome.

- 6.14. Dr Tsokkos changed Mrs Taylor's medication from Aropax to Aurorix on 22 March 2000. Dr Tolis changed it back to Aropax on 27 April without consulting Dr Tsokkos about why she thought Aropax was inappropriate, without a proper appreciation of Mrs Taylor's history, and without warning her of the potential lethality of the two drugs in combination.
- 6.15. Dr Buckley described switching antidepressants in this way as 'particularly dangerous' (T109).
- 6.16. As to whether Dr Tolis' actions were causatively related to Mrs Taylor's death, two factors are significant:
- the drugs dispensed on 17 July 2000 were prescribed on 30 January and 22 March 2000, that is before he became involved in her treatment;
  - even though he didn't issue the warning about the combination of drugs, such warnings were given by Dr Tsokkos, Mr Fietz and, most significantly, Ms Caird on the day before Mrs Taylor died.
- 6.17. Therefore, even though I am critical of Dr Tolis for his treatment of, and his general attitude to Mrs Taylor as a patient, I find that his actions were not causatively relevant to her death.

*Key Words: Drug Overdose; Suicide; Medical Treatment; Pharmacy; Serotonin Syndrome; Aropax; Paroxetine; Aurorix; Moclobemide*

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

*Seal the 11th day of July, 2002.*

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*Coroner*