CORONERS ACT, 2003

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, 13th, 16th, 17th, 19th, 20th, 25th and 26th days of August 2010 and the 22nd day of June 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Melissa Jay Tatchell.

The said Court finds that Melissa Jay Tatchell aged 28 years, late of Clifford House, 4 Farrant Street, Prospect, South Australia died at Prospect, South Australia on the 8th day of October 2007 as a result of bronchopneumonia complicating oxycodone toxicity. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Melissa Jay Tatchell was 28 years of age when she died on Monday 8 October 2007. She was found dead in bed in a supported residential facility known as Clifford House which is situated at 4 Farrant Street, Prospect. Ms Tatchell had been a resident at the facility since the previous Thursday, 4 October 2007. Immediately prior to that she had resided for four nights at a motel in the city following her discharge from a social admission for two nights at the Royal Adelaide Hospital (the RAH).

1.2. Ms Tatchell's death was unexpected and the police became involved in the matter. A post-mortem examination of Ms Tatchell's body was conducted by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia. Dr Gilbert has reported that the cause of Ms Tatchell's death was bronchopneumonia complicating oxycodone toxicity[1]. I find that to have been the cause of Ms Tatchell's death. Oxycodone is one

[1] Exhibit C21

of the opioid class of drugs. It is used principally for relief of pain of moderate to severe intensity. Oxycodone is a strong analgesic and is only obtained on prescription. It is available in two forms. The conventional form of oxycodone is a short acting drug that is normally taken four times per day. Oxycontin is a brand name for a controlled release product that extends the duration of action of oxycodone so that it is only taken twice each day. The drug acts over a period of about 12 hours, irrespective of the dosage. Oxycontin tablets have a coating that assists in its controlled release. It is for this reason that oxycontin tablets should not be cut in half before administration because the breaking of the integrity of the coating will cause the drug to be released at a much faster rate into the blood stream than is desirable or safe. This case concerns the substance oxycontin. The drug in whatever form has a number of side effects such as sedation and it may also cause depression of breathing in the person who takes it. This substance was found to be in Ms Tatchell's bloodstream in a toxic and potentially lethal concentration. In addition to oxycontin, the substances clozapine, diazepam (a benzodiazepine commonly known as valium) and nordiazepam (the metabolite of diazepam) were also found to be in Ms Tatchell's bloodstream at post-mortem. Clozapine is an antipsychotic drug. The concentration of clozapine was unremarkable, as were the concentrations of diazepam and nordiazepam which are anti-anxiety substances. Benzodiazepines and oxycodone used in combination can have additive central nervous system and respiratory depressant effects.

1.3. Dr Gilbert explained that respiratory depression as a result of the toxicity generated by the substances, together with suppression of the cough reflex, was likely to have contributed to the development of bronchopneumonia in Ms Tatchell. I accept that evidence.

1.4. The drugs oxycontin and diazepam had been prescribed for Ms Tatchell. There is no evidence that clozapine had been so prescribed and it is not known where Ms Tatchell obtained that substance from.

1.5. Ms Tatchell had a history of anorexia nervosa, bulimia, asthma, borderline personality disorder, depression, osteoporosis and vitamin D deficiency. When her body was weighed at post-mortem she was 29 kilograms. She was 157 centimetres in height. Her body mass index was 11.8 which is well below the normal range of 20 to 25. The weight of 29 kilograms represents profound underweight.

1.6. Dr Gilbert's post-mortem report is dated 21 October 2008, which is approximately one year after Ms Tatchell's death. On the other hand, the toxicology report that revealed the concentrations of drugs to which I have already referred is dated 23 November 2007 and was available on or about that date[2]. Thus the cause of death was available to be known in November of 2007, that is to say within a matter of weeks of Ms Tatchell's death. However, an assumption was made on the part of the investigating authorities that Ms Tatchell's cause of death had been the complications and consequences of her profoundly underweight condition due to anorexia nervosa. Although Ms Tatchell's condition may have contributed to her death as the drugs may have had a greater effect on her having regard to her gross underweight, the cause of her death was essentially the effects of oxycodone toxicity.

1.7. It was not until some time after Dr Gilbert's post-mortem report became available that investigating police became aware of that cause of death. The investigating police officers were very junior in rank and experience. Even allowing for that fact I was surprised to find that it was not until this Inquest was well under way that either of them knew what the actual cause of death had been. Detectives had also had an early interest in the matter, as had the two investigating officers' Sergeant. The fact that police were unaware of the precise cause of death meant that no meaningful investigation as to the circumstances of Ms Tatchell's death commenced until over a year following her death. It is of paramount importance that investigating police make themselves aware of the precise cause of death at the first available opportunity, regardless of whether the forensic pathologist who performed the post mortem of a deceased person has yet to report formally. It is the responsibility of investigating police to investigate the circumstances of a death that is reportable to the State Coroner in the light of the anatomical cause of that death. It is difficult to see how that responsibility can be discharged if investigating police do not acquaint themselves with the cause of death as soon as it is established.

1.8. As a consequence of the delay in this matter evidence was lost. Medications found in Ms Tatchell's possession as well those held for her by the staff of Clifford House, and the containers in which the substances had been contained, were destroyed well before this Inquest commenced. In addition, important records about Ms Tatchell that formed part of the facility's records and which should have been seized by police

[2] Exhibit C3a

right at the outset were lost. Statements were not taken from important witnesses until a considerable period of time had elapsed since Ms Tatchell's death.

1.9. It was not reasonable for an assumption to have been made that the cause of Ms Tatchell's death was due to anorexia nervosa when it was clear on the day of her death that she had been in possession of substances that if taken in a toxic quantity could have accounted for death regardless of her debilitated condition. The failure of police to investigate the matter in the light of the established cause of death greatly hampered this inquiry and is a matter that is to say the least undesirable and one that hopefully will not be repeated.

1.10. In this Inquest I examined a number of issues. Those issues including the following:

- How Ms Tatchell came to be in possession of the drugs oxycodone and diazepam;
- The circumstances in which Ms Tatchell came to ingest a fatal quantity of the substances in combination;
- Whether Ms Tatchell received optimal medical treatment and advice concerning her consumption of the substances prior to her death;
- Whether Ms Tatchell deliberately took a quantity of these substances with an intention to end her own life;
- Whether Ms Tatchell's death could have been prevented.

2. Ms Tatchell is found deceased

2.1. Ms Tatchell had last been seen conscious and awake on Sunday evening, 7 October 2007 which was the day before her death. Ms Tatchell shared a room with a woman by the name of Carol Rebers. Ms Rebers explains in a statement to police[3] that Ms Tatchell had at one point apologised to Ms Rebers after she had turned on the light to read. Ms Rebers herself fell asleep at about 11pm. Up until that point she had formed the impression that Ms Tatchell was in a happy frame of mind. There was other evidence to suggest that Ms Tatchell had eaten, or at least ordered, pizzas that Sunday evening.

2.2. The next morning at about 7:30am Ms Rebers tried to wake Ms Tatchell for breakfast but she would not wake up. Ms Rebers thought that she was in a deep sleep and that

[3] Exhibit C4a

there was no problem. In her statement[4] she asserts that at that point Ms Tatchell was breathing heavily and was still warm to touch. Ms Rebers returned to the room at about 12:30pm to see if Ms Tatchell was coming to lunch. Ms Tatchell was still in bed and still appeared to be sleeping. Ms Rebers did not attempt to wake her on this occasion.

2.3. One of the facility's cleaners, a Ms Helen Blunsden, says in her witness statement[5] that sometime between 9:30am and 10am on the Monday she entered the room occupied by Ms Tatchell and Ms Rebers in order to clean it. Ms Tatchell was still in bed. Ms Blunsden had no reason to think anything other than that Ms Tatchell was still sleeping. Ms Blunsden suggests in her statement that she was fairly certain that she saw Ms Tatchell's foot move at one point and she had the feeling that she was generally moving in her bed. She did not detect any unusual breathing pattern. She cleaned Ms Rebers' half of the room and did not disturb Ms Tatchell. She was in the room for about 15 minutes.

2.4. On Monday 8 October 2007 one of the proprietors of the facility, Ms Suzanne Marshall, was on duty as manager. Ms Marshall gave a formal statement[6] to the police later that day. She also participated in a recorded interview[7] with police sometime later. Ms Marshall gave evidence in the Inquest. Ms Marshall states that she attended Ms Tatchell's room at about 5pm to let her know that tea was being served. She found Ms Tatchell lying in bed on her right side facing the wall, still in her pyjamas. At that point she was warm to touch but was not breathing. Ms Marshall started to perform CPR until the arrival of the ambulance service about 2 minutes later. It is clear, however, that by that time Ms Tatchell had passed away.

2.5. Ms Tatchell had stayed in bed for the entire day. It is likely that she had remained in bed the whole time since last seen awake by her roommate the previous evening. Ms Marshall explained in her evidence that it is not unusual for residents of such a facility, having as they do physical and psychological problems, to stay in bed for most of a day.

2.6. Naturally the police were called and they attended the facility.

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[4] Exhibit C4a
[5] Exhibit C5a
[6] Exhibit C6a
[7] Exhibit C6b

2.7. The death of Ms Tatchell was investigated by two junior and relatively inexperienced police officers. They were Probationary Constable Shaun Ahern, who is now a non-probationary officer, and Constable Howard Baker. These are the two officers who, as I have said, did not know of Ms Tatchell's cause of death until this Inquest. I do not speak critically of these two officers as they were relatively junior. In my view the task at hand required police intervention at a more senior level, especially in the light of the fact that even at that stage one possible explanation for Ms Tatchell's death was drug related.

2.8. The Court has had to reconstruct what medication had been in Ms Tatchell's possession from an inventory of sorts that Constable Ahearn prepared. In Ms Tatchell's room a number of inhalers were located. These did not have any relevance. However, there were a number of tablets located within the room clearly belonging to her. This included a jar of potassium chloride tablets and a sachet of paroxetine tablets. In the normal course of events, medications such as these ought to have been surrendered by the resident to the management of the facility so that they could have her medication made up into Webster packs that would then be kept by the management and administered to the resident in accordance with the resident's prescription. I addition, there are certain obligations upon facilities of this nature to manage a resident's medications. None of the substances found in Ms Tatchell's room were found in her bloodstream post-mortem.

2.9. At one point during the course of the police attendance Constable Baker retrieved from the management office further medication that belonged to Ms Tatchell. The precise circumstances in which these medications came to be there is not entirely clear and I will come back to that in a moment. In Constable Ahearn's statement[8] he lists these substances as follows:

> 'One (1) bottle of Potassium chloride (600mg) tablets
>
> One (1) bottle of nitrazepam (5mg) tablets
>
> One (1) bottle of diazepam (5mg) tablets
>
> One (1) sachet of oxycontin hydrochloride (80mg) tablets (containing 4 of 10)
>
> One (1) sachet of panafen plus tablets (ibuprofen 200mg/codeine phosphate 12.8mg)
>
> One (1) prescription for celecoxib 200mg capsules (celebrex)' [9]

[8] Exhibit C10a
[9] Exhibit C10a, page 3

It will be noted that there was a 'sachet' of oxycontin hydrochloride tablets. The size of the tablets was 80mg. These tablets were the slow release preparations of oxycodone. I understand the sachet was a common foil blister pack that would originally have contained 10 tablets. There were now 4 tablets. There was also a bottle of diazepam tablets 5mg in size. There is no means by which the number of diazepam tablets can now be established. Any written instructions as to dosage and frequency of administration that may have accompanied the medications were destroyed along with the medications. In particular, a box that may have contained the oxycontin sachet and which might have borne dosage instructions was either not seized or, if it had existed, was no longer available at the time of the police attendance.

2.10. It seems clear that, at least as far as the oxycontin and diazepam medications were concerned, that these had not been supplied to Ms Tatchell during the course of her residency at Clifford House. It is likely that these medications had been supplied on 28 September 2007 in accordance with a prescription that had been made available by a doctor on that day. More of that later.

3. Ms Tatchell's ingestion of medication while at Clifford House

3.1. As will be seen this issue is obfuscated firstly by the fact that any record of administration of medications to Ms Tatchell that may have been raised within Clifford House at the time were not seized by police, and secondly by the imperfect recollections of witnesses through the effluxion of time.

3.2. Ms Tatchell had arrived at Clifford House on Thursday 4 October 2007. On that occasion there is no evidence that she produced any medication to management. Ms Tatchell had come from other residential accommodation where she had spent some days since her release from the RAH on 30 September. At some point in time over the weekend following 4 October 2007 Ms Tatchell surrendered some of her medications to management and this explains how it came to pass that on 8 October 2007 management was in possession of some of those medications.

3.3. There was a body of evidence concerning the contents of Ms Tatchell's stomach at post mortem and what this may have implied in terms of recent ingestion of medication and of oxycontin in particular. In the event, I did not find that evidence to be particularly informative. It has been quite impossible for this Court to investigate

properly when, and in what quantities, Ms Tatchell may have consumed oxycontin in the period leading up to her death. Suffice it to say, there is no evidence that she ingested oxycontin or diazepam after Ms Rebers saw her awake for the last time on Sunday evening. Neither of those substances were found in her room.

3.4. However, there is other evidence, much of which is difficult to reconcile, from staff members at the facility that suggests that Ms Tatchell may have been given one or more oxycontin tablets, or possibly half tablets, in the 48 hour period prior to her being located deceased. I speak here of the evidence of Mr Darrell Lear who performed a variety of roles at the facility including that of weekend supervisor and night caretaker, and that of Ms Dolores Brine who also performed a number of different roles at the facility.

3.5. Mr Lear was asked to give a formal witness statement for the first time on 14 August 2010[10], which was during the course of the Inquest. However, he had provided a statement to Constable Baker on the day of Ms Tatchell's death. This statement had been recorded in Constable Baker's notebook and had been signed by Mr Lear. Mr Lear gave evidence in the Inquest. On the day of Ms Tatchell's death, Mr Lear had told Constable Baker that on the Saturday he had performed the duties of manager. Ms Tatchell had come to the office at about 5pm on that day seeking her medication. He was expecting to find her medication in a Webster pack as that is how a resident's medication is usually packed, but he did not locate one for her. He kept looking and eventually found a plastic bag containing her medication. He told Constable Baker that he had given Ms Tatchell one 80mg oxycontin tablet. It is probable that he was able to describe what he had given her by selecting the medication out of those that Constable Baker had seized from the office. However, in the statement that he made in August 2010, by which stage the medications had been destroyed, he did not specify the medication that he had given to Ms Tatchell on the Saturday except to say that it had come out of a plain white box which had contained small oval shaped tablets of a purplish or mauve colour. He said that Ms Tatchell herself had indicated the box of tablets that she wanted from the bag. Mr Lear stated that there were dosage instructions on the box. He said in the formal statement that he could not remember what the medication was, but he recalled that the dosage instructions were for Ms Tatchell to take half a tablet. He believed that it was prescribed to be taken twice per

[10] Exhibit C34

day. He provided half a tablet to her. He says he may have recorded in Ms Tatchell's progress notes the fact that he had administered that one half tablet. This now cannot be known because the records were not seized and have since been lost. His two statements cannot be fully reconciled. However, my view is that there had been less room for error when on 8 October 2007 he told Constable Baker, probably by reference to the actual exhibit, that he had given oxycontin to Ms Tatchell. What is difficult to reconcile is that he does not appear to have said on 8 October 2007 that it was half a tablet that he had given her. Nevertheless, the more recent assertion by Mr Lear that he gave her half a tablet has an element of truth to it when it is considered that, as will be seen, Ms Tatchell had been mistakenly told by clinical staff at the RAH, where a week earlier she had been admitted, to take the 80mg oxycontin tablets in that fashion.

3.6. Ms Brine provided a witness statement dated 14 August 2010[11] and she also gave evidence. She states that at about 3pm on the Sunday afternoon she was with another staff member by the name of Vicki Holland when Ms Tatchell approached them. Ms Tatchell said that she had been sleeping all day and was feeling tired. Ms Brine for herself observed that Ms Tatchell was drowsy, appeared vague and was not as 'chirpy' as she had appeared the day before. During this conversation Ms Tatchell handed her a brown paper bag that was unsealed and which contained medication. Ms Brine took possession of that. Ms Brine suggests that the bag contained a white plastic bottle and a rectangular box of tablets as well as a small, squarer box of tablets. There were dosage instructions on both boxes and on the bottle. Ms Brine could no longer say what the medications were. Ms Tatchell did not say anything to her about what the medications were. She did say that she had already taken her morning medications that day. At about 5pm that afternoon Ms Tatchell came to the office. On this occasion Ms Brine provided some medication to her in accordance with the instructions on the packages. She recalled that she at least gave Ms Tatchell half a tablet from the white bottle. The statement of Ms Holland[12] confirms that she and Ms Brine were approached by Ms Tatchell on the Sunday but states that she could not recall whether Ms Tatchell gave Ms Brine anything during this conversation and that would include, of course, a bag of medications. The fact that Ms Brine asserts that she gave Ms Tatchell a half tablet is of interest as it is consistent with her having

[11] Exhibit C32
[12] Exhibit C33

given Ms Tatchell a half tablet of oxycontin. However, the assertion that the half tablet came out of a bottle would not be consistent with it having been oxycontin. Ms Brine's evidence did not preclude the possibility that she may have given Ms Tatchell other medication besides the half tablet from the bottle. It does not preclude the possibility that she may have given her oxycontin as well as something from the bottle.

3.7. The presentation by Ms Tatchell of her medication in a brown paper bag on the Sunday afternoon to Ms Brine, and Mr Lear's evidence that there was a plastic bag of medication already in the possession of management on the Saturday is also difficult to reconcile except to say that Ms Tatchell may have been deliberately selective as to what and when she was prepared to hand over to management. There is no evidence as to how and when and to whom Ms Tatchell's medication was handed to management such that Mr Lear could administer it to Ms Tatchell on the Saturday. Again, the facility's records concerning Ms Tatchell, if seized, may have elucidated that fact.

3.8. Ms Marshall told me in evidence that on the Monday when she came to the facility to work as manager, Ms Tatchell's medications were sitting on her desk. The expectation was that they would be put into a Webster pack by a visiting chemist. She said that there were boxes and bottles and that everything that they had for Ms Tatchell was given to police. I am satisfied that the only oxycontin remaining in Ms Tatchell's overall possession at Clifford House were the 4 tablets of 80mg each that were contained within the single 10 tablet sachet located in the management office. There was no other oxycontin found, and certainly no oxycontin found in her room. There was also only the one bottle of diazepam tablets found in the management office.

3.9. In my view it is quite impossible, and it would be unfair even to attempt, to draw any meaningful conclusion about the administration of medication by staff of the Clifford House facility. It is possible that both Mr Lear and Ms Brine made a note of what Ms Tatchell was administered either on the Saturday, the Sunday or both and, indeed, such a note should have been made. The difficulty is that investigating police did not seize any of Ms Tatchell's records made to date. Thus, the evidence as to what Ms Tatchell was administered, when, and in what quantity and whether it was by way of whole tablets or half, cannot be reconstructed with sufficient clarity to enable any

finding to be made as to how Ms Tatchell came to ingest a toxic quantity of oxycontin and diazepam. What can be said with some degree of confidence is that what Ms Tatchell brought to the facility was the medication that had been in her possession for some time prior to that weekend and that what she ingested that caused her death was part of that supply. Much of what follows in this finding concerns how it came to pass that Ms Tatchell was in possession of the oxycontin and diazepam in the first instance and whether her possession of it had been appropriate having regard to the strength of the tablets supplied, its quantity and its dosage.

3.10. There is one further matter that I should mention about the management of Clifford House. Ms Marshall told me in evidence that she kept the facility's documentation relating to Ms Tatchell's accommodation for about a year, and that it was kept on a desk in her office. She believed that the documentation would have contained a medication sheet. Her expectation had been that police would, at some point in time, eventually come and seize it. In the event this did not happen. Ms Marshall was unable now to account for the whereabouts of the documentation. I did not draw any sinister conclusion from the failure of Ms Marshall to locate and produce any of that documentation. Ms Marshall and a manager by the name of Ms Schulz gave evidence at some length during the course of the Inquest. After seeing both witnesses give evidence, and in particular see Ms Marshall give evidence over a long period of time, I was satisfied that there had been no attempt on the part of management at Clifford House to withhold any evidence from police, including any documentary records that may have been in existence in respect of Ms Tatchell and which might have consisted of written evidence of the administration of medication to her by Clifford House staff.

4. Ms Tatchell's movements in the weeks prior to her death

4.1. Ms Tatchell had been a patient of the Eating Disorders Unit situated in Flinders Medical Centre until July 2007. There was a scheduled appointment for her to attend at the Unit on 2 August 2007. She did not keep that appointment. Dr Peter Gilchrist was the Clinical Director of the Eating Disorders Unit at the Flinders Medical Centre. Dr Gilchrist gave evidence in the Inquest. I do not need to go into the detail of Dr Gilchrist's evidence. Suffice it to say that Ms Tatchell's compliance with treatment and management administered by the Unit was not ideal and her condition was not responsive to standard treatment in the way that had been hoped. Dr Gilchrist rejected any suggestion that had been faintly made throughout this period that Ms

Tatchell's treatment had been unreasonably withheld from her by the Unit in light of her disappointing response to treatment. Dr Gilchrist explained to me that he had spoken to Ms Tatchell and had told her that before they would be prepared to admit her to another inpatient program, they needed some undertaking on her part relating to her motivation to change[13].

4.2. Ms Tatchell in due course became resident in Catherine House which is a facility in the city. Dr Gilchrist told me that he maintained contact with the management of Catherine House about Ms Tatchell. It eventually became apparent that Catherine House itself was unable to meet Ms Tatchell's needs.

4.3. Dr Gilchrist told me that if Ms Tatchell had returned to the Unit with a more positive frame of mind and a greater determination to get better, they would have recommenced an entirely new process of treatment. If she had presented to the Flinders Medical Centre as physically unwell she would have been assessed under their relevant protocol and probably would have been admitted medically and then been reviewed and her situation reassessed[14].

4.4. Dr Gilchrist rejected the notion that his Unit had effectively abandoned Ms Tatchell. As I say, I do not need to go into the details of his evidence but it is sufficient it to record that I wholly accept what Dr Gilchrist told me about Ms Tatchell and his description of the circumstances in which she came to be disengaged from the services that the Unit provided. In my view it would be wrong for anyone to suggest that Dr Gilchrist's Unit abandoned Ms Tatchell.

4.5. Ms Tatchell underwent admissions to the RAH in July and September of 2007. She was in the RAH overnight from 6 September to 7 September. She would again be admitted for two nights from 28 September to 30 September.

4.6. On 18 September 2007 Ms Tatchell commenced residence at Catherine House. I did not understand Catherine House to be a supported residential facility. It was hoped that Ms Tatchell would soon be placed in a supported residential facility of her preference, not Clifford House, but this did not come to pass.

[13] Transcript, page 150
[14] Transcript, page 224

4.7. By the time of her admission to Catherine House Ms Tatchell was not coping very well. Quite apart from her eating disorder issues and other co-morbidities not the least of which was her physical frailty, she had apparently sustained a painful injury in a fall and this had been the reason for her hospitalisation in early September. Ms Tatchell's accommodation at Catherine House would be short-lived. She would be back in the RAH by the end of the month. It was during her time at Catherine House that she was placed in possession of the analgesic oxycontin by a GP. It is apparent that staff at Catherine House were ill equipped to support Ms Tatchell and to assist with her health difficulties in any meaningful way and it is apparent that Ms Tatchell's medication regime was problematic for them. That Catherine House could no longer help her in her predicament is detailed in a letter that was prepared by the management of Catherine House on 28 September 2007 and which made its way onto Ms Tatchell's RAH file upon her admission on that day[15]. It was noted in the letter that Ms Tatchell was currently very underweight and was experiencing a multitude of physical ailments. The observation was made that she was so weak that she was struggling to complete activities of daily living. The letter referred to her current regime of strong pain management medication. It suggested that Catherine House did not offer the level of support that Ms Tatchell currently required. The letter suggested that the only appropriate course of action in relation to Ms Tatchell was hospital admission.

4.8. The RAH final separation summary[16] relating to the earlier RAH admission on 6 and 7 September 2007 included reference to her fall and generalised pain in the neck, back and knee. It also referred to a weight at that time of 30 kilograms. She had been discharged with advice to increase her potassium levels. The separation summary described her discharge medication that included nitrazepam, but did not include oxycodone in either of its forms. There is no evidence that Ms Tatchell had been administered oxycontin during this admission, but there is evidence that she had been given oxycodone in small dosages during an admission in July.

4.9. Between 7 September and 28 September 2007, the intervening period between her two RAH September admissions, Ms Tatchell presented on a number of occasions to a general medical practice. This practice was known as the Para Hills Medical Clinic at Bridge Road, Para Hills. Ms Tatchell saw a Dr Somnath Ghosal for the most part.

[15] Exhibit C14a, page 23
[16] Exhibit C14a, pages 82 and 83

It was during this period that Ms Tatchell was prescribed both diazepam (valium) and oxycontin. The oxycontin was prescribed by a doctor other than Dr Ghosal. I return to the details of her presentations to this practice in another section.

4.10. Also prior to Ms Tatchell's admission to the RAH, she had seen a psychologist on a number of occasions. That psychologist was a Ms Penny Janis who saw Ms Tatchell on 22 August 2007, 29 August 2007 and 26 September 2007. She also saw Ms Tatchell after her discharge from the RAH on the second occasion on 3 October 2007.

4.11. Ms Tatchell remained within the RAH between 28 September 2007 and her discharge on 30 September 2007. She had presented at the Emergency Department of the RAH and had been kept there for two nights on the basis of a social admission. By then it will be remembered that the management of Catherine House had indicated that there was nothing further they could do for Ms Tatchell.

4.12. I return to the details of the RAH admission in another section.

4.13. Upon Ms Tatchell's discharge from the RAH on 30 September 2007 she resided at Kiwi Lodge, which is a motel in Hindley Street, Adelaide. This accommodation had been arranged by the community liaison team at the RAH.

4.14. Ms Tatchell resided at Kiwi Lodge from 30 September to 4 October 2007, the day that she moved into Clifford House.

4.15. As seen, Ms Tatchell remained at Clifford House from Thursday 4 October 2007 to the day of her death which was Monday 8 October 2007.

5. Ms Tatchell is supplied with oxycodone

5.1. I have already referred to the fact that Ms Tatchell consulted Dr Somnath Ghosal at the Para Hills Medical Clinic. Dr Ghosal supplied a statement to the Inquest[17]. He saw Ms Tatchell for the first time on 10 August 2007. Prior to this Ms Tatchell had seen another doctor in the practice in relation to her eating disorder, amongst other difficulties.

[17] Exhibit C28

5.2. When seen by Dr Ghosal for the first time she weighed only 30 kilograms. Dr Ghosal explains in his statement that when Ms Tatchell first consulted him she was taking diazepam (valium) and nitrazepam. She had not been prescribed oxycontin.

5.3. Following Ms Tatchell's fall and overnight admission to the RAH on 6 and 7 September 2007, Dr Ghosal saw her on 10 September 2007 and 19 September 2007. On the first of those occasions Dr Ghosal prescribed panadeine forte in relation to the pain which Ms Tatchell complained of as the result of her fall. He prescribed a quantity of 20 such tablets. He also prescribed her valium on this occasion.

5.4. Ms Tatchell was also seen on other dates in September 2007 by locum practitioners and it is recorded that her weight at that time was 34 kilograms.

5.5. On 19 September 2007, which was the last occasion that Dr Ghosal personally saw Ms Tatchell, she presented at the practice and asked Dr Ghosal to prescribe more valium as well as oxycontin. She specifically requested oxycontin. As far as Dr Ghosal was aware, Ms Tatchell had not been prescribed oxycontin in the past. Dr Ghosal declined to prescribe either of those two medications. The valium tablets that Dr Ghosal had prescribed on 10 September 2007 had been 5mg tablets and the prescription was for Ms Tatchell to take 1 tablet, 3 times per day as required. The quantity prescribed was 50 tablets. On that basis, if Ms Tatchell had been taking the medication in accordance with the prescription, Ms Tatchell should still have had some valium left when Dr Ghosal saw her on 19 September 2007. As far as pain relief was concerned, Dr Ghosal provided Ms Tatchell with a further prescription for panadeine forte. The quantity was again 20 tablets to be taken as required. It is clear from Dr Ghosal's computerised notation in relation to this presentation that, among other things, Ms Tatchell had painful and swollen ankles and back. On this occasion Dr Ghosal made the following computerised notation:

> 'Rquested (sic) more valium & oxycontin today. Declined.
> She should not have valium for next 10 days.'

In an addendum statement provided to the Inquest dated 12 August 2010[18], Dr Ghosal explains that it is not his practice to prescribe oxycontin to any person unless it had been ordered by a hospital or a specialist or where the patient was in extreme pain, for example a cancer patient. He explains that his reluctance to prescribe oxycontin on

[18] Part of Exhibit C28

this occasion was due to his concern that the drug has serious side effects, can be addictive and patients can develop a tolerance over time which means that one would need to increase the dosage to achieve a therapeutic benefit.

5.6. In the event, Ms Tatchell would subsequently be prescribed oxycontin 40 mg twice per day by another doctor in the practice. In his original statement to police Dr Ghosal suggested that there would be:

> 'Some concern and consideration about Melissa's anorexic condition when deciding to provide oxycontin.' [19]

Dr Ghosal went on to explain that a dosage of 40mg twice per day is an adult dosage for a person of reasonable weight, whereas Ms Tatchell's last recorded weight had been 34 kilograms on 14 September 2007. In fact, 40mg would not be a starting dose in any event.

5.7. Ms Tatchell returned to the practice on the afternoon of 21 September 2007, two days after Dr Ghosal saw her. By then Dr Ghosal had taken leave. On this occasion she saw Dr Nimrod Smit who prescribed oxycontin tablets for Ms Tatchell in circumstances that I will discuss shortly. Dr Smit gave evidence in the Inquest. The 21 September 2007 ought to be memorable for Dr Smit because it was his first day of medical practice in Australia. Dr Smit is from South Africa. He came to Australia on 11 September 2007. His medical qualifications were obtained from the University of Pretoria in South Africa. He practised as a doctor in a group practice in Pretoria for approximately 8 years. He spent some time in the South African Defence Force and possesses an aviation medicine diploma conferred by that Force. He was also in sole practice for approximately 8 years immediately before his migration to Australia. As of September 2007 he practised under supervision. Since the events with which this Inquest is concerned, Dr Smit has passed the examinations for admission to the Royal Australian College of General Practitioners. Dr Smit now practices in his own right as a general practitioner. Between 11 September and 21 September 2007, the day on which Dr Smit commenced supervised practice at the Para Hills Medical Clinic, he underwent some training in respect of computerised record systems and also received tuition in relation to Medicare billing procedures. He was under the supervision of Dr Bryan Simon who practised at Kensington but who also had a connection with the Para Hills practice. He received his training in relation to the computerised records

[19] Exhibit C28, page 5

system at the Para Hills Clinic from Dr Simon himself. Prior to this Dr Smit had not used any form of computerised records system in South Africa. He was not computer literate as at September 2007. Dr Smit told me that as of September 2007 he was unfamiliar with the drug oxycodone and its slow release version, oxycontin. He told me that neither medication was available for prescription in South Africa. Rather, pain relief substances such as codeine, tramadol and dextro propoxyphene were the commonly prescribed strong pain relief medications in that country. Dr Smit had no experience with oxycodone or oxycontin prior to coming to South Australia and, indeed, no experience with the prescription of the substances prior to the day he saw Ms Tatchell on 21 September 2007. Dr Smit acknowledged that he was familiar with the well known MIMS publication that describes drugs and medications and their properties, but suggested that the South African version would not have described medications that were unavailable for prescription in that country such as oxycodone and oxycontin.

5.8. Dr Smit gave me to understand that although when he saw Ms Tatchell on 21 September 2007 he had access to computerised records of her prior attendances at the practice, such as that involving Dr Ghosal on 19 September 2007, he had no knowledge of the existence of, or indeed how to access, other documentation that may have been available in the practice such as the practice's copy of the RAH's final separation summary of 7 September 2007 that included, among other things, a list of her discharge medications that did not include oxycontin or any other opiate based painkiller.

5.9. Dr Smit made his own entry within Ms Tatchell's computerised records and it describes very little in terms of Ms Tatchell's presentation. There is some reference to X-rays of Ms Tatchell's left and right ankles, but does not set out any detail relating to her presenting complaint or her diagnosis. Other than references to X-rays, it simply records what medication Dr Smit prescribed for Ms Tatchell. However, there is a letter within the practice's records that Dr Smit wrote about Ms Tatchell on 27 September 2007 in an endeavour to get her admitted to the Lyell McEwin Hospital. In the event she was admitted to the RAH. The letter written by Dr Smit provides some information in relation to his consultation with Ms Tatchell on 21 September 2007. Dr Smit stated in the letter that Ms Tatchell had advanced anorexia nervosa,

had recently fallen and had multiple soft tissue injuries. Within the letter Dr Smit has described Ms Tatchell as weighing 'only 45kg'.

5.10. Dr Smit told me that on 21 September 2007 Ms Tatchell mentioned the fall earlier that month. She appeared to be in significant discomfort. He observed naturally enough that Ms Tatchell was thin, but he told me that she said to him that she weighed 45 kilograms. He did not weigh her. I refer to the fact that at post-mortem Ms Tatchell was 29 kilograms. I also refer to the fact that on 13 and 14 September 2007, only a week or so before her presentation to Dr Smit, she had weighed 34 kilograms. Clearly she was not 45 kilograms when Dr Smit saw her, but I have no doubt that she told Dr Smit that she weighed 45 kilograms and that Dr Smit accepted her statement about that. I point to the fact that he wrote the letter that referred to that weight and, in addition to that, it is clear that when she attended the RAH a week later she told staff there that her recent weight was 45 kilograms. In any event, not a great deal turns on her actual weight because, by any measure, she was profoundly underweight.

5.11. Dr Smit told me that Ms Tatchell described persistent lower back, ankle and foot pain. Dr Smit thought that Ms Tatchell may have sustained a fracture of one of the small bones in her feet and that she had an associated lower back injury. He also considered the possibility that she had a soft tissue injury. He advised her to have further X-rays taken. At the time of his examination Ms Tatchell appeared to be in pain and so there was discussion between them about pain relief. Dr Smit explained to me that, but for her concurrent use of an antidepressant, he may have considered prescribing tramadol for the pain. Ms Tatchell herself told Dr Smit that she had been prescribed oxycontin, 40mg twice per day during her hospital admission and that this had helped a lot for the pain. This was not true. She went on to say that since her release from hospital she had seen some locum practitioners as well as Dr Ghosal and they had prescribed panadeine forte for her which had not helped very much.

5.12. Dr Smit acknowledged in his evidence that he saw in the computerised records the note relating to Ms Tatchell's consultation with Dr Ghosal on 19 September 2007, two days earlier. Specifically he saw the notation whereby Ms Tatchell had requested more valium and oxycontin and that Dr Ghosal had declined both. Dr Smit interpreted that entry as indicating that Dr Ghosal had declined valium only, and in support of this interpretation he pointed to the added notation that Ms Tatchell should not have valium for the next 10 days. Dr Smit did not interpret Dr Ghosal's note as

meaning that oxycontin had also been declined. However, two things are clear from Dr Ghosal's note and they are that oxycontin was not prescribed by Dr Ghosal and that Dr Ghosal prescribed panadeine forte for the pain

5.13. Dr Smit told me that he examined the MIMS entry in relation to oxycontin before he prescribed it for her. He prescribed 40mg tablets to be taken twice per day. His prescription was for a quantity of 60 tablets. His intention had been to place Ms Tatchell in possession of a sufficient quantity to last her a month. In prescribing that quantity Dr Smit was unaware that a pharmacist would only be permitted to supply 20 tablets at a time. In the event that was all that was supplied to Ms Tatchell on this occasion.

5.14. The entry in MIMS that Dr Smit said he consulted was tendered to the Inquest[20]. The relevant entry clearly indicates that the usual starting dose for oxycontin is 10mg, 12 hourly, meaning twice per day. It will be seen that Dr Smit prescribed, in effect, four times that quantity of 40mg twice per day. Dr Smit told me in evidence that he prescribed this quantity because of Ms Tatchell's assertions that she had been prescribed 40mg twice per day in hospital, her dosage having been titrated to that level within the hospital. Evidence was adduced from a number of sources, including that of Professor Jason White, who is a Professor of Pharmacology at the University of SA, that oxycontin, being an opioid, can involve the development of quite marked tolerance on the part of the patient. Tolerance might develop to a level where the patient may need to be prescribed the substance in increasing quantities. However, a dosage as high as 40mg as a starting dose would be inappropriate in a person of Ms Tatchell's stature and weight. In effect, Dr Smit told me that he had believed that Ms Tatchell had already been titrated and had developed a sufficient tolerance to the substance to enable her to be prescribed 40mg twice per day. He also believed that she was 45kg.

5.15. As things transpired, Dr Smit again prescribed oxycontin for Ms Tatchell a week later on 28 September 2007. Ms Tatchell did not attend at the practice that day and Dr Smit did not see her. Rather, Dr Smit had a conversation with one of the practice nurses about Ms Tatchell. The issue of concern on that occasion was whether Ms Tatchell should be admitted to the Lyell McEwin Hospital in accordance with Dr Smit's letter of the day before. As part of his conversation with the nurse, Dr Smit

[20] Exhibit C29a

told me in evidence that he learned for the first time that a week earlier Ms Tatchell had only been supplied with 20 tablets of oxycontin, not the 60 tablets that he had actually prescribed. Dr Smit told me that he largely had to reconstruct his thought processes as to why he agreed to again supply oxycontin and in a larger dosage on this occasion. He assumes that he must have concluded that Ms Tatchell would run out of her tablets in the ensuing days which as it happens comprised a long weekend. Thus he concluded that he must have decided on 28 September 2007 to prescribe a further quantity of oxycontin. On this occasion, however, it is clear that he prescribed 80mg tablets to be taken once daily. His prescription on this occasion was for 20 such tablets. In his evidence Dr Smit gave me to understand that his thought processes in relation to a prescription of 80mg tablets may have involved an intention on his part to allow for a longer period of pain relief of 24 hours, and that is why it was prescribed daily but in a greater dosage. This would have been an erroneous approach because, regardless of whether the dosage is 40mg or 80mg, the drug is released at the same rate and pain relief is only experienced over a period of 12 hours. Furthermore, it is not as if 80mg oxycontin tablets can be cut in half. As alluded to earlier, this is due to the fact that the active component of the medication will be released much more quickly than desired.

5.16. There was an obvious alternative explanation as to why Dr Smit may have prescribed 80mg tablets and that was that, believing that the tablets could easily be cut in half, he wanted to place twice the quantity of oxycontin in Ms Tatchell's possession because he now knew that 20 tablets was the maximum that would be supplied. He said he could not recall whether that was part of his thinking. He said he also could not recall whether he was aware that it was an inappropriate practice to cut slow release tablets in half. He made that assertion notwithstanding that the MIMS entry relating to oxycontin plainly states that one should not break, chew or crush the tablets[21]. Whatever Dr Smit's thinking, the prescription for 80mg tablets was ill considered.

5.17. On 28 September 2007 Dr Smit also prescribed valium for Ms Tatchell in the form of 5mg tablets, the prescription being one tablet twice per day. The quantity prescribed was 50. I have already referred to the fact that a benzodiazepine such as valium can act with an opiate such as oxycontin to increase the effect of the two drugs in combination.

[21] Transcript, page 421

5.18. On 28 September 2007 the prescriptions for both medications was faxed to a Chemplus pharmacist in Hutt Street in the city. Both prescriptions were filled. I have already referred to the fact that on the day of Ms Tatchell's death, police located four 80mg oxycontin tablets and a quantity of 5mg valium tablets in the management office of the Clifford House facility. There is no evidence that Ms Tatchell came into possession of a further quantity of valium tablets or of 80mg oxycontin tablets, or for that matter oxycontin tablets of any dosage, in the period between 28 September 2007 and the day of her death.

5.19. I had my misgivings about a number of aspects of Dr Smit's evidence. The way in which he interpreted Dr Ghosal's note, in which the latter had indicated that he had declined Ms Tatchell's requests for valium and oxycontin, had its difficulties. Dr Ghosal had in fact declined both valium and oxycontin on 19 September 2007 and indeed had prescribed another painkiller which was panadeine forte. The more sensible interpretation of the note would have been that Dr Ghosal had not only declined valium, but had declined oxycontin as well. If only two days later Dr Smit had interpreted the notation in that fashion, he would have been naturally hesitant about prescribing oxycontin for Ms Tatchell, especially having regard to his own unfamiliarity with the drug. Dr Smit's explanation or reconstruction about why he prescribed the further quantity of oxycontin in the dosage of 80mg tablets was also unconvincing. Dr Smit's asserted belief that Ms Tatchell was opiate tolerant to the point where she could withstand dosages considerably in excess of the usual starting dosage, based as it was upon unsubstantiated claims made by herself, was also difficult to understand.

5.20. I observed Dr Smit give evidence at length. Notwithstanding some of the difficulties that I have identified as to the content of Dr Smit's evidence, I did not notice anything about Dr Smit's demeanour that suggested that he was in any way deliberately trying to mislead the Court. In addition, I could identify no reason why Dr Smit, on his first day of practice in Australia, would desire deliberately to place a dangerous substance in a dangerous quantity in the possession of an emaciated, debilitated and possibly doctor shopping young woman. In the event, I have concluded that Dr Smit's approach to his patient, both on 21 September and 28 September 2007, was borne out of naivety having regard to his inexperience in practice in Australia and his inexperience with the substance oxycontin.

6. Ms Tatchell's psychological treatment

6.1. I have already referred to this issue. Ms Penny Janis, who is a psychologist, saw Ms Tatchell on four occasions that spanned either side of Ms Tatchell's hospitalisation at the RAH at the end of September 2007. Ms Janis gave evidence in the Inquest.

6.2. Ms Tatchell was originally referred to Ms Janis by Dr Ghosal. The first two appointments that Ms Tatchell had with Ms Janis occurred in August 2007. I need only refer to the two appointments that post dated the prescriptions of oxycontin that had been made out by Dr Smit. The two appointments in question occurred on 26 September 2007 and 3 October 2007. The first of those appointments preceded Ms Tatchell's admission to hospital. The second appointment occurred in the period between Ms Tatchell's discharge from the RAH and her taking up residence in Clifford House.

6.3. It should be borne in mind that as a psychologist Ms Janis was not able to prescribe medication as part of any psychological treatment. The question for discussion in this section is whether anything that occurred as between Ms Tatchell and Ms Janis might have altered the eventual fatal outcome in this matter, and in particular whether Ms Janis as one of Ms Tatchell's health care providers should have informed Ms Tatchell's doctors of her client's worrying presentation during this period.

6.4. What is apparent is that during the session of 26 September 2007 Ms Janis noted that Ms Tatchell was slurring her speech and looked very spaced out. When she questioned Ms Tatchell about that, Ms Tatchell said that she was on 'really strong painkillers'[22]. She told Ms Janis that she was taking panadeine forte, oxycodone and valium. Ms Tatchell suggested that she had been sleeping very poorly recently and made what Ms Janis thought was an exaggerated claim that she had been awake for 48 hours straight. Ms Janis noted that Ms Tatchell looked quite dazed and appeared to drift off as if sleeping, which Ms Tatchell herself attributed to the strong painkillers. Ms Tatchell in this interview referred to her accident and fall earlier that month.

6.5. When Ms Janis next saw Ms Tatchell on 3 October 2007, Ms Tatchell was very anxious about her accommodation circumstances. By then she had been asked to

[22] Exhibit C26c

leave Catherine House and had been discharged from the RAH. She was staying in the Kiwi Lodge in Hindley Street. A significant proportion of this session was taken up by Ms Tatchell speaking on the phone to an RAH Community Liaison Team worker in order to meet a deadline about committing to residency at Clifford House which was not her preferred facility. On this occasion Ms Janis has noted that Ms Tatchell said that she was still taking panadeine forte. She also said that she had told the director of Catherine House that she had been having problems with oxycodone - 'that she was imagining things like having a conversation whilst asleep - like she is talking in her sleep'.

6.6. In the period between 26 September and 3 October 2007 inclusive, Ms Janis did not have any communication with Ms Tatchell's medical practitioners. However, on 19 October 2007, after Ms Tatchell's death, Ms Janis had a telephone conversation with Dr Ghosal. Ms Janis made a note of this conversation which included an assertion that in the final two sessions with Ms Tatchell the latter had 'appeared to be affected by the pain medication she had been taking'.

6.7. In her evidence before me Ms Janis said that she did not have an appreciation of the nature of oxycodone or oxycontin. It is apparent, however, that Ms Janis must have realised that this medication was having a heavily sedating effect upon her client. Ms Janis acknowledged that the reason for Ms Tatchell having slurred speech on 26 September 2007 and for her 'spaced out' appearance was due to her having taken strong painkillers[23]. When asked in cross-examination as to why after 26 September 2007 Ms Janis had not informed the referring medical practitioner of Ms Tatchell's presentation that day, she explained that Ms Tatchell had given her reason to believe that she was maintaining regular contact with her general practitioner. As well, she would not have wanted to jeopardise building up a therapeutic relationship with Ms Tatchell by communicating unnecessarily and privately with her doctor. She did not believe that Ms Tatchell was at risk and that, in any event, it was not as if Ms Tatchell had fallen asleep during the course of the session. Ms Janis asserted that they were able effectively to discuss a number of matters. The note made by Ms Janis of this session does bear out the fact that although Ms Tatchell was affected by her medication, there was significant discussion about Ms Tatchell's wellbeing and her current social circumstances.

[23] Transcript, page 329

6.8. Ms Janis denied that in the final consultation of 3 October 2007 Ms Tatchell had been manifestly and adversely affected by her medication. Her note of her telephone conversation with Dr Ghosal on 19 October 2007 on the other hand, taken at face value, suggests that Ms Tatchell had been so affected in both of the final two sessions with Ms Janis. However, the actual note made by Ms Janis of the 3 October 2007 session says nothing to the effect that Ms Tatchell was then currently affected by her medication. It is my view more probable that Ms Janis' note of her 19 October 2007 conversation with Dr Ghosal is inaccurate. I accept Ms Janis' evidence that Ms Tatchell did not appear to be adversely affected by medication on 3 October 2007. Ms Tatchell's known demeanour on that day would tend to negate any such presentation. During this session she was for the most part on the phone trying to organise accommodation and there is no suggestion that she was functioning other than appropriately. There is a notation in the RAH notes[24] made by a member of the Community Liaison Team that on 3 October 2007 Ms Tatchell, in the company of that worker, had inspected Clifford House and had 'asked very relevant questions'[25]. It is evident that this occurred prior to the psychologist's appointment. There is no suggestion of any adverse effect that might have been caused by medication during this encounter. The phone call of that afternoon made in the presence of Ms Janis was also the subject of a note made by the RAH worker with whom Ms Tatchell spoke. There is no suggestion in that note of any adverse demeanour being exhibited by Ms Tatchell[26].

6.9. Thus, any alleged omission on the part of Ms Janis to inform Ms Tatchell's medical practitioner about the adverse effects that the prescribed medication was having on her client could only be entertained in the context of Ms Tatchell's condition during the 26 September 2007 session. Mr Manetta, counsel for Ms Janis, submitted to me that such criticism would be unwarranted. He makes the point that one would not expect a psychologist to second guess the treatment of medical practitioners or to report every passing complaint about her client's situation, including a complaint about the effect of medication. There is force in what Mr Manetta has submitted. It is certainly arguable that it would be viewing the matter too much with the benefit of hindsight to suggest that Ms Janis should automatically have contacted the prescribing medical practitioner and that it was unreasonable for her not to have done so. Sadly

[24] Exhibit C14a
[25] Exhibit C14a, page 153
[26] Exhibit C14a, page 154

we now know that it probably would have been of benefit for Ms Janis to have done so. It will be remembered that the session on 26 September 2007 occurred two days prior to Dr Smit's further prescription of oxycontin at the increased dosage of 80mg. A call from Ms Janis to the Para Hills Medical Clinic advising them of the effect that the medication was having on Ms Tatchell during what were meant to have been therapeutic psychological sessions may have resulted in Ms Tatchell's medication being revised and may have prevented the further ill advised prescription of 28 September 2007 taking place.

6.10. The issue as to what Ms Janis might reasonably have been expected to do is not free from difficulty, and there was no evidence before the Court as to what might be considered to be proper professional practice in this regard. While some professional health care providers may have informed the referring practitioner to Ms Tatchell's presentation, particularly if that care provider was familiar with a drug such as oxycontin, it is very difficult to suggest on the evidence that was presented to the Court that Ms Janis in her circumstances had unreasonably failed to do so.

7. Ms Tatchell's hospitalisation at the RAH between 28 and 30 September 2007

7.1. Ms Tatchell was brought to the Emergency Department of the RAH during the afternoon of 28 September 2007. She was in the first instance seen by a Dr Yasmine Ali Abdelhamid. It was noted as part of Ms Tatchell's clinical assessment that day that she had presented to the Emergency Department having been 'evicted' from Catherine House due to their inability to manage her increased level of care. It was noted at the RAH that Ms Tatchell was not suicidal or psychotic. She was examined both medically and psychiatrically. Her history including anorexia nervosa was noted, as was her recent fall. A note was made upon her presentation that her medications included 'oxycontin 40mg PO BD' which refers to 40mg taken orally twice per day. It also referred to her taking 'diazepam 10mg PO TDS' which means 10mg taken orally three times per day. As to whether this information was imparted orally to the doctor or whether this notation was made by way of the sighting of medication in her possession, it seems unlikely that it would have been the latter in light of the fact that Ms Tatchell's most recent prescription of oxycontin was for 80mg once per day and for diazepam 5mg and that the discrepancies in dosages would have been obvious if Ms Tatchell had actually shown the doctor her medication. The

statement of Dr Abdelhamid tendered to the Inquest[27] does not elucidate whether or not Ms Tatchell was actually in possession of and showed the doctor her medication. In any event, Ms Tatchell explained at this point that she had ongoing lumbar back pain that was 'slightly relieved' by oxycontin but that she felt sedated. On this occasion she claimed that her recent weight was 45 kilograms which was in keeping with what she told Dr Smit. Dr Abdelhamid did not prescribe any further medication. Regardless of whether Ms Tatchell actually showed medical staff her medications, I think it is clear that no medication was surrendered by Ms Tatchell to staff on this occasion.

7.2. Dr Abdelhamid handed Ms Tatchell over to the Emergency Department registrar who on this occasion was Dr Jacinta Regudo. Dr Regudo gave evidence in the Inquest. During the course of Dr Regudo's examination of Ms Tatchell one of the Emergency Department consultants made inquiries of staff at Catherine House and it is noted that the staff member of Catherine House indicated that they had been unable to cope with the demands of Ms Tatchell such that it had become a safety issue for them. It was specifically noted that Ms Tatchell had been walking around the house 'demanding medications'[28].

7.3. A psychiatric assessment was performed on 28 September 2007. The assessment was made that Ms Tatchell was distressed at the thought of being homeless which at that point in time she was. She denied any suicidal intent or thoughts of deliberate self-harm. A provisional diagnosis of 'accommodation crisis' was made[29]. A plan was made to refer Ms Tatchell to the Homeless Team. In due course the placements firstly at Kiwi Lodge in Hindley Street and then Clifford House at Prospect were arranged.

7.4. Meanwhile it was considered appropriate that Ms Tatchell undergo what is termed a 'social admission' within the RAH. Dr Regudo explained to me that a social admission implies that the person does not have any medical basis for admission but that it is considered unsafe for the person to be discharged from the hospital. Accordingly, Ms Tatchell was admitted and accommodated within the Emergency Extended Care Unit (EECU), now known as the Short Stay Ward, which is part of the

[27] Exhibit C8a
[28] Exhibit C14a, page 133
[29] Exhibit C14b, page 136

RAH Emergency Department. Ms Tatchell would stay in this accommodation for that night and the following night.

7.5. As far as Ms Tatchell's medication was concerned as at 28 September 2007, Dr Regudo told me that in the normal course of events a patient's medications such as oxycontin and diazepam would be continued but would be administered by the hospital. She explained that Emergency Department practice meant that they would not change the regular or chronic medications of a patient[30]. It seems plain enough that on 28 September 2007 no medication chart that governs the administration of medication to a hospital patient was prepared within the hospital. The earliest charted administration of medication to Ms Tatchell appears on 30 September 2007. It was not clear to the Court why this was so, especially having regard to the fact that Ms Tatchell made it clear from the outset that she was taking prescribed medication. Absent the hospital preparing a medications chart, if she was to receive any medication at all, it would have had to have been at her own administration[31]. It is clear that this is what in fact happened until her self administration was discovered by clinical staff the following day. To begin with Ms Tatchell retained her medications and administered it to herself within the EECU. Clearly self medication of substances such as these by patients within a public hospital is an undesirable state of affairs. When Dr Regudo was asked in cross-examination as to how one might prevent people from self medicating, she said '*I have no answer to that*'[32]. Dr Regudo did not recall any consideration being given by her to the question of whether Ms Tatchell's asserted dosage of 40mg of oxycontin twice per day was appropriate in her circumstances. Dr Regudo had a very limited recollection of Ms Tatchell.

7.6. A perusal of the RAH notes relating to Ms Tatchell's previous presentations in late September 2007 would have revealed that Ms Tatchell had not been prescribed oxycontin during her hospitalisation there earlier in September. All that would have been revealed was the administration of 2.5mg oxycodone on isolated occasions during another admission to the RAH in July of that year.

7.7. On 29 September 2007, the day following Ms Tatchell's admission, it was noted during the course of the afternoon by nursing staff that Ms Tatchell had been drowsy.

[30] Transcript, page 456
[31] Transcript, page 471
[32] Transcript, page 471

This is noted at 1:35pm[33]. At 2:35pm it was again noted by nursing staff that upon conversing with Ms Tatchell she would apparently fall asleep mid sentence and, on occasions, her face would fall into a plate of food. At 7:45pm she was again noted to be drowsy but towards the end of the shift she was engaging with nursing staff more appropriately. A note timed at 9pm records that during a discussion with Ms Tatchell it was finally revealed that Ms Tatchell had been administering her own medication while in hospital. It was noted that Ms Tatchell, who usually took oxycontin 40mg twice per day, had been accidentally taking 80mg twice per day. The note went on to suggest that this was a possible explanation as to why Ms Tatchell had been drowsy. A note was made that her medications were taken from her that evening. There is further reference to this issue recorded on a Metro Home Link referral form which forms part of the RAH records relating to this admission[34]. It is recorded there that Ms Tatchell had experienced an accidental overdose with her own medication and that the stated explanation for this was that the chemist had filled out her script incorrectly insofar as 80mg tablets had been supplied instead of 40mg tablets. While the consumption of 80mg tablets probably explained Ms Tatchell's presentation on 29 September 2007, the assumption that 80mg tablets had been wrongly supplied by the pharmacist was inaccurate as the fact of the matter was that 80mg tablets of oxycontin had been prescribed by Dr Smit and they had been supplied in accordance with the prescription.

7.8. To my mind the inference that Ms Tatchell was self medicating prior to the 9pm note on 29 September 2007 is overwhelming. In addition, it seems very clear that Ms Tatchell had been consuming 80mg oxycontin tablets. It is not possible to reconstruct how many such tablets Ms Tatchell had consumed within the RAH before they were removed from her on the evening of 29 September 2007, but it is clear that her drowsy presentation is explicable on the basis of her consumption of oxycontin, much as it was when it was when Ms Janis saw her on 26 September 2007.

7.9. In the opinion of the Court it would have been far better if when Ms Tatchell first presented to the Emergency Department of the RAH on 28 September 2007 and volunteered that she had been medicating with oxycontin and diazepam, clinical staff at the hospital at that time had taken it upon themselves to remove her medication

[33] Exhibit C14a, page 142
[34] Exhibit C14a, page 150

from her possession, had reassessed her medication needs and had administered her medication accordingly.

7.10. At the time with which this Inquest is concerned Dr Lourelei Sabio was a resident medical officer employed in the Emergency Department at the RAH. She was on duty on 30 September 2007, the day of Ms Tatchell's eventual discharge. It will be recalled that the nursing note of the previous evening recorded that Ms Tatchell's medications had been removed from her possession. For the first time during this admission, a medication chart was prepared in respect of Ms Tatchell on the morning of 30 September 2007[35]. The chart in the first instance was written up by Dr Sabio. Dr Sabio in effect became the prescribing medical practitioner in respect of Ms Tatchell's medication regime during the course of that day. Among other medications, Dr Sabio wrote up a prescription for the administration of oxycontin at 40mg twice per day to be administered at 9am and 10pm. As well, she wrote up a prescription for diazepam (valium) at 10mg three times per day to be administered at 9am, 1pm and 6pm. There was no re-evaluation of the appropriateness of either prescription. It will be noted that these prescriptions are in exact accordance with what Ms Tatchell had revealed to staff within the Emergency Department at the time she was first examined. Accordingly, an inference is available that Dr Sabio simply prepared a prescription in accordance with what Ms Tatchell had originally described as far as her medication regime was concerned. In the event, it appears that 40mg of oxycontin was administered to Ms Tatchell within the hospital at 11:25am that day. This must have come from the hospital's own pharmacy. There does not appear to have been any second administration prior to her discharge later that evening. There does not appear to have been an administration of diazepam on that day. However, any pre-existing error in prescription of oxycontin in terms of the magnitude of the dosage, be it 40mg or 80mg, was perpetuated.

7.11. Dr Sabio gave evidence in the Inquest. She told the Court that medical practitioners at the RAH Emergency Department do not change the medication of a patient in Ms Tatchell's circumstances unless there is a pressing concern at the time of their presentation. She said that this was so because there was an assumption that the prescribing practitioner knew the patient better than what they did. She said:

[35] Exhibit C14a, pages 165 and 166

> '… so we really have no business in mixing and changing what regular medications or treatment regime that the patient is already on, unless there's a pressing issue at that particular point in time when we saw the patient.' [36]

Dr Sabio suggested that this was the 'usual procedure' within the RAH[37].

7.12. Dr Sabio also suggested that medication that has been taken from a patient during the course of an admission would normally be returned to them upon discharge[38].

7.13. Dr Sabio acknowledged that she had written up the medication chart to which I have already referred but stated that she had no real recollection of the circumstances pertaining to this or of Ms Tatchell in general. She acknowledged, as she had to, that it was her decision to place Ms Tatchell on the oxycontin prescription of 40mg twice per day.

7.14. During the course of the afternoon of 30 September 2007 motel accommodation was arranged for Ms Tatchell at Kiwi Lodge. Ms Tatchell was ultimately discharged at 8:15pm and was accompanied by a carer. This is recorded in a retrospective nursing note timed at 8:55pm following her discharge[39]. A final separation summary was prepared that evening. It is evident, and I so find, that this document was prepared by Dr Sabio[40]. As part of the management plan described within this document, Ms Tatchell's discharge medications are listed. Diazepam is not listed, but oxycontin is listed and the details of the prescription are 40mg, oral, twice a day. The duration of administration is described as being 'long term'. When one examines the nursing note prepared at 8:55pm following Ms Tatchell's discharge, it is recorded that the discharge letter was given to Ms Tatchell. It also records that the patient was educated by the medical officer not to take the full dose of oxycontin but to take half a tablet. This to my mind can mean nothing other than that Ms Tatchell was advised to refrain from taking the whole of an 80mg tablet but to take half an 80mg tablet at a time and to do so twice per day. Dr Sabio acknowledged that she had prepared the final separation summary. She acknowledged that she may well have been involved in a 10am to 8pm shift that day, or a 1pm to 11pm shift although she could not recall for certain. Whatever her shift, it seems clear enough that Dr Sabio was heavily involved in the procedures involving Ms Tatchell's discharge. While the matter is not

[36] Transcript, page 231
[37] Transcript, page 231
[38] Transcript, page 233
[39] Exhibit C14a, page 149
[40] Exhibit C14a, pages 127 and 128

entirely clear, it would seem to be a logical conclusion that the advice that was given to Ms Tatchell not to take a full dose but to take a half a tablet of oxycontin was given by Dr Sabio. Dr Sabio, whilst having an imperfect memory of these events, acknowledged the possibility that the medical officer who had given that advice to Ms Tatchell was herself[41]. She also acknowledged as part of this that she may have given advice about taking half a tablet as opposed to a full dose. She said that although she had no clear recollection, there was a possibility that this may have happened[42]. When asked whether her state of knowledge as a medical practitioner was such at the time that she may have given advice like that, she said:

> 'I really can't tell. But - because I'm just trying to piece out the story.' [43]

7.15. Whoever gave the advice to Ms Tatchell that she should take half a tablet of oxycontin, which must have been a reference to the 80mg tablets that Ms Tatchell had brought with her to the hospital, the advice was erroneous and contrary to the nature of oxycontin being a slow release substance. It also flies in the face of clear advice that was available in the MIMS publication to the effect that oxycontin tablets should not be broken. The advice given to Ms Tatchell was of course erroneous because it would mean that although Ms Tatchell would be consuming 40mg of oxycontin twice per day, it would not be released gradually but, because of the breaking of the integrity of the coating, more rapidly and in a greater quantity than was safe.

7.16. There is no evidence that before Ms Tatchell's discharge the RAH placed Ms Tatchell in possession of any more medication, and in particular 40mg tablets. In my view it is more likely, and I so find, that what remained of the medications that Ms Tatchell had arrived with at the RAH was returned to her on discharge, including the 80mg oxycontin tablets and the 5mg diazepam tablets. It will be remembered that Ms Tatchell had been supplied with twenty 80mg oxycontin tablets on 28 September 2007. There is no evidence that she ever received 80mg tablets from any other source. To my mind what remained of those 20 tablets was returned to Ms Tatchell on 30 September and that when the police attended at Clifford House what they seized were the last 4 tablets of that quantity of 20.

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[41] Transcript, pages 249-249
[42] Transcript, page 249
[43] Transcript, page 253

7.17. There is no evidence relating to Ms Tatchell's pattern of consumption of either oxycontin or diazepam between Sunday 30 September 2007 and the following weekend when she was resident at Clifford House.

8. Conclusions

8.1. It is clear, and I so find, that Ms Tatchell consumed an amount of oxycontin prior to her death that was in a toxic and potentially lethal quantity in and of itself. As well, there were the additional effects of diazepam, a substance that was also found in her bloodstream.

8.2. There is no evidence from which any conclusion can be drawn that Ms Tatchell deliberately took her own life. It is more likely in my view that she was unaware of how inappropriately high the dosage of oxycontin that had been prescribed for her actually was. In addition, she was given erroneous advice about cutting 80mg oxycontin tablets in half. This may also have contributed to the potentially lethal level of oxycontin in her bloodstream. However, the exact circumstances in which she came to consume this amount of oxycontin cannot be reconstructed with certainty.

8.3. I do say, however, that Ms Tatchell's death could have been avoided if Dr Smit in the first instance had been more careful about prescribing an opiate based substance in respect of which he had no prior experience. Her death may also have been avoided if staff at the RAH had re-evaluated Ms Tatchell's oxycontin regime and had not discharged her with 80mg tablets in her possession. The difficulty with Ms Tatchell's possession of 80mg tablets was that she might either take an inappropriate dose whole or might cut them in half, both of which methods of consumption would have been dangerous for her.

9. Recommendations

9.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

9.2. I make the following recommendations:

1) That the Chief Executive Officer of the Australian Health Practitioner Regulation Agency cause advise to be given to all medical practitioners supervising the training of overseas medical practitioners working in general practices, that they should specifically supervise and oversee the prescription of opiate based medication that an overseas practitioner might wish to prescribe, especially in circumstances where the overseas practitioner lacks familiarity with the relevant medication. In this regard such overseas medical practitioners, during the course of their training, should be instructed to seek the advice of their supervisor before any such prescription is made;

2) That the Chief Executive Officer of the Australian Health Practitioner Regulation Agency advise all registered psychologists to be vigilant in identifying, in clients, signs of overmedication and that if they do identify such a client, they should consider advising the referring general practitioner to those circumstances;

3) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital consider instructing medical staff within the Royal Adelaide Hospital Emergency Department, in circumstances where the patient is kept within the Emergency Department for an extended period, to review the medication requirements of a patient, particularly where the patient has been prescribed opiate based medications and has exhibited signs of excessive sedation;

4) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital instruct nursing and medical staff of the Emergency Department to sight any medication in the possession of a presenting patient and to remove any medication from the possession of the patient in circumstances where the patient is admitted either to a general ward or to the Short Stay Ward;

5) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital ensure that the necessary steps are taken to prevent patients within the Emergency Department Short Stay Ward from self medicating;

6) That the Director of the Emergency Department and Director of Critical Services at the Royal Adelaide Hospital ensure that clinical staff are made aware of the

need to avoid erroneously advising patients that they may break slow release medications such as oxycontin before consumption.

Key Words: Medication; Inexperience (general practitioner); Drug Overdose

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 22nd day of June, 2011.

Deputy State Coroner

Inquest Number 20/2010 (1468/2007)