MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Margaret Joy O'Donnell

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Margaret Joy O'Donnell;
b) Ms O'Donnell's death occurred in the circumstances set out in this finding;
c) The cause of Ms O'Donnell's death cannot be determined; and
d) Ms O'Donnell died between 9 and 15 June 2018 at Glenorchy in Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Ms O'Donnell's death. The evidence includes;

- The police report of death for the coroner;
- Affidavits of life extinct and identification;
- Opinion of the forensic pathologist regarding cause of death;
- Toxicology report regarding analysis of Ms O'Donnell's post mortem blood sample;
- General practitioner records from Connewarre Clinic for Ms O'Donnell;
- Mental Health Services records for Ms O'Donnell;
- Tasmanian Health Service records;
- Affidavit of Amanda Achter, daughter of Ms O'Donnell;
- Affidavit of Kiah Davey, long-time friend of Ms O'Donnell;
- Affidavit of Barbara Campbell, friend and neighbour of Ms O'Donnell;
- Affidavit of Denise Parker, neighbour who requested police assistance after concern for Ms O'Donnell's welfare;
- Affidavit of Constable Olivia Pearce - Tomes, who attended the scene and investigated the death;

- Report from Dr Scott Chamberlen regarding the capacity and health of Ms O'Donnell's grandmother, with whom Ms O'Donnell lived at the time of her death;
- Report of Dr A J Bell, coronial medical consultant, who reviewed the medical circumstances of Ms O'Donnell's death;
- Pharmaceutical Services Branch report and records regarding prescribing of Schedule 8 substances to Ms O'Donnell;
- Report from Dr G Pitt regarding prescribing to Ms O'Donnell; and
- Report from Dr Nicolle Ait Khelifa, Consultant Psychiatrist and Addiction Medicine Specialist who reviewed the prescribing of medication by Dr Pitt to Ms O'Donnell.

Background

Margaret Joy O'Donnell (born Margaret Joy Tomkinson) was born on 1 December 1966 and was aged 51 years at the time of her death. She was the child of Susan O'Donnell and Anthony Tomkinson. She had one sister, Roseanne. Ms O'Donnell was estranged from Roseanne and her biological father. Her mother, with whom she had little contact since the age of 10 years, died of natural causes in 2014. When Ms O'Donnell was a child her mother married Peter O'Donnell and Ms O'Donnell took her step-father's surname.

At the time of her death, Ms O'Donnell lived with her grandmother, Esma Coombe ("Esma") (now deceased) in Chapel Street in Glenorchy and done so since 2010. She was not employed at the time of her death and she was in receipt of a disability support pension.

Ms O'Donnell had four children: Amanda Achter, Leah Smith (deceased), Daniel Williams and Suzanne Williams.

Ms O'Donnell was in a relationship with James Holmstrom throughout the 1980s, during which time Amanda was born. Ms O'Donnell and Mr Holmstrom separated about three years after Amanda was born and Amanda went to live with Mr Holmstrom.

Ms O'Donnell married Steve Smith in the late 1980s, during which time they had Leah. Leah was severely disabled and placed into foster care. She died at the age of 8 years as a result of her disability. Ms O'Donnell and Mr Smith were divorced by 1996.

In the early 1990s Ms O'Donnell formed a relationship with John Williams during which time Daniel and Suzanne were born. Ms O'Donnell and Mr Williams separated in the late 1990s. Mr

Williams was granted custody of both Daniel and Suzanne following a custody dispute. Ms O'Donnell had little contact with Daniel and Suzanne after custody was granted to Mr Williams.

Ms O'Donnell had several forms of employment throughout her life, the last of which was in about 2002, when she worked as a freelance photographer.

Ms O'Donnell's health

Ms O'Donnell suffered from a number of long-term physical and mental health issues. Primarily, she suffered fibrocystic breast disease causing severe, chronic pain for which she required high dosage narcotic analgesia. She had undergone multiple breast lump excisions as a result of this condition. Other health conditions described in her records include lifelong asthma and periods of pyelonephritis and biliary colic. In 2017 she underwent successful surgery for bladder cancer. She had a past history of alcohol misuse and was a heavy smoker. She was under the care of her general practitioner, Dr Greg Pitt, on a regular basis from 2010 until her death.

In about 2008, Ms O'Donnell was diagnosed with, and underwent some treatment for, anxiety, depression and post-traumatic stress disorder. She reported to her psychologist at the time that she was affected by numerous incidents of past trauma and stressful events in her life. Her mental health continued to be poor until her death, affecting her sleep and ability to function. However, the medical records do not indicate that she suffered significant suicidal ideation.

In 2009, Ms O'Donnell was flagged as a suspected medication abuser on Royal Hobart Hospital records. There is very little other evidence in her medical history that she misused her prescription medication, sourced medication illegally or visited multiple doctors simultaneously to obtain excessive supplies of medication.

Since about 2000, Ms O'Donnell had been prescribed Schedule 8 narcotic substances by treating medical practitioners because of her chronic breast pain. Because of this lengthy history of prescribing and her need for them, she was assessed as being "drug dependent" by Dr Pitt in January 2011, shortly after he first started to treat her. Dr Pitt notified Pharmaceutical Services Branch of this fact and therefore required authorisations to prescribe Schedule 8 narcotic substances to Ms O'Donnell. I deal with this issue below in more detail. Dr Pitt continued to prescribe the narcotic oxycodone until her death. He also prescribed her a variety of other medications to assist her manager her chronic pain, mental health conditions and asthma.

In 2018, Ms O'Donnell was prescribed oxycodone, gabapentin, chlorpromazine and lorazepam by Dr Pitt. Dr Pitt last saw her on 15 May 2018, at which time he issued her regular monthly prescriptions for chlorpromazine, oxycodone and lorazepam.

Circumstances of death and investigation

In the two weeks before her death, Ms O'Donnell regularly attended the Calvary Hospital to visit her grandmother, Esma, who had been a patient since approximately 1 June 2018. Esma was 90 years of age at that time and suffered from a number of terminal medical conditions. The date of Ms O'Donnell's last visit is not able to be confirmed.

Ms O'Donnell was last known to be alive on 9 June 2018, when her neighbour, Barbara Campbell, spoke to her on the phone. Ms Campbell lived across the road from Ms O'Donnell and was good friends with Esma. She had known Ms O'Donnell for over 8 years. Ms Campbell also saw Ms O'Donnell the day prior and did not perceive anything out of the ordinary about her health or wellbeing at that time.

At 3.00pm on 15 June 2018, police officers attended Ms O'Donnell's home after concerns were raised for her welfare by another neighbour, Denise Parker. Ms Parker outlined to police that Ms O'Donnell had not been seen for at least 3 days, which she considered to be unusual as she was aware that Ms O'Donnell had been regularly driving to visit her grandmother in hospital.

Upon arrival, the attending police officers observed mail in the letter box and clothing hanging on the washing line. The residence was secure with all windows and doors locked. Most of the curtains in the residence were open. A locksmith attended the residence and entry was gained through the front door.

Ms O'Donnell's body was located in bed in the spare bedroom. She was found lying on her left side, facing the window and had the blankets pulled up to her face. She was clearly deceased, with her body in a state of decomposition. She was wearing underwear and a long-sleeved top.

A thorough investigation of the scene was undertaken by the attending police officers, including a Forensic Services officer. The keys to the front door were located on the inside of the door in the lock. Numerous medications prescribed to both Ms O'Donnell and Esma were located inside the residence. Police also located some expired medications inside a first aid kit in the bathroom. More recent medication was located in the living room, next to the lounge suite. The medication belonging to Ms O'Donnell and Esma was seized by the police officers.

I find that the residence was secure prior to Ms O'Donnell's death and there was no evidence of a disturbance at the scene or foul play. There were no observed or reported signs of physical injuries upon her body. There were no items reported stolen or missing from the residence and Ms O'Donnell's personal belongings were all accounted for.

An autopsy upon Ms O'Donnell was undertaken on 18 June 2018 by forensic pathologist, Dr Donald Ritchey. Dr Ritchey was unable to determine an anatomical cause of death, reporting that there were significant limitations in determining any due to Ms O'Donnell's state of decomposition. He did not detect evidence of violent injury. He did observe lung disease caused by smoking and calcified ulcerated atherosclerosis of the aorta but no natural disease that accounted for death.

A post-mortem blood sample from Ms O'Donnell was analysed by a forensic scientist, Neil McLachlan-Troup, at Forensic Science Service Tasmania. The results revealed that there was a high level of alcohol in Ms O'Donnell's blood. There were also numerous drugs detected in her blood. These included her own prescribed medications - oxycodone, gabapentin, mirtazapine and chlorpromazine. There were also reported fatal levels of the Schedule 8 opioid analgesics methadone and hydromorphone. These were not prescribed to Ms O'Donnell but had been prescribed to Esma at that time and likely were taken from her supply. There were other drugs found in her system, namely amiodarone, codeine, propranolol, paracetamol and promethazine. It appears that the codeine was from Esma's prescribed quantity located at the scene. The source of the others in this group is unclear.

Both Dr Ritchey and Mr McLachlan-Troup, in considering the toxicological results, noted that the stated quantities of all substances detected in the sample would have been significantly affected by decomposition processes and may be artificially elevated from the actual levels present at the time of death due to potential post-mortem redistribution and interferences present during analyses. Mr McLachlan-Troup noted, however, that the respiratory depressant effects of methadone are significantly enhanced when combined with the other central nervous system depressant substances.

Dr Ritchey opined that mixed drug toxicity was the more likely cause of death but the difficulty with the interpretation of the toxicology results and the limitations of the autopsy prevented him from being able to determine the cause of Ms O'Donnell's death.

There is no strong evidence to suggest that Ms O'Donnell intended to end her own life. There was no suicide note or similar messages left by her, nor any history of deliberate self-harm. The

affidavit evidence of those who knew Ms O'Donnell also indicates that she would be unlikely to do so. However, I cannot rule out the possibility of suicide. Her grandmother, with whom she was very close, was no longer in the house and her mental health may have deteriorated. Alternatively, Ms O'Donnell may have taken the opportunity with Esma's absence to misuse her (Esma's) medication, and died unintentionally from its toxic effects together with the effects of her own medication.

In summary, I cannot determine Ms O'Connell's cause of death. However, I am satisfied that her death was not the result of homicide. I find that Ms O'Donnell died either intentionally or unintentionally as a result of mixed drug (including alcohol) toxicity, or as a result of undetermined natural causes.

Schedule 8 prescribing

This investigation has been extended as I was required to consider potential prescribing issues by Dr Pitt raised in the original report of the Acting Chief Pharmacist on behalf of Pharmaceutical Services Branch (PSB).

PSB has statutory responsibility for administering the *Poisons Act* 1971 and the *Poisons Regulations* 2018. The Act and Regulations regulate the administration of all narcotic (or Schedule 8) substances in the State. Oxycodone, being the substance prescribed to Ms O'Donnell, is a Schedule 8 substance.

PSB keeps a record of all Schedule 8 prescribing on its database. The records show who received, who prescribed and where and when substances were dispensed. In addition to prescribing records, records are kept of all the authorities issued by PSB under the *Poisons Act* to medical practitioners authorising the prescription of narcotic substances. If a patient has previously been declared "drug dependent" by a medical practitioner, an authorisation to continue to prescribe is required immediately. As noted above, Ms O'Donnell had been declared drug dependent and authorities were required to allow prescribing to her.

This aspect of the investigation required me to seek a detailed report from Dr Pitt regarding his treatment and prescribing to Ms O'Donnell as well as further reports from the Acting Chief Pharmacist and an addiction medicine specialist.

The concerns of the Acting Chief Pharmacist in relation to Dr Pitt's treatment and prescribing included the following;

- The concurrent prescribing of multiple sedative and affect-modulating substances, substantially increasing the risk of dangerous sedation, accidental overdose and preventable death, which regime was not supported in an evidence-informed practice environment;
- The lack of sufficient review of Ms O'Donnell's prescribing regime by a pain medicine specialist and insufficient risk mitigation strategies given the high risk medication regimen;
- A documented history of failing to seek legal authorities under section 59E of the *Poisons Act* 1971 in order to prescribe Schedule 8 narcotics to Ms O'Donnell; and
- Failing to use the Real Time Prescription Monitoring system (DORA) so that he might view clinical information and dispensing data relating to Ms O'Donnell's Schedule 8 substances.

In his detailed response, Dr Pitt provided an explanation in respect of each of the issues raised by the Acting Chief Pharmacist. He stated that Ms O'Donnell was a difficult and complex patient whom he maintained on a closely monitored drug regime that, whilst not ideal, controlled her multiple complaints. He also stated that Ms O'Donnell did not at any time display behaviours predictive of drug misuse and, if she had, he would have taken various steps to restrict her prescribing.

Dr Pitt also responded to the issue of providing Schedule 8 substances to Ms O'Donnell without valid authorities under the *Poisons Act 1971*. He provided various reasons for some of the breaches, including that PSB did not send reminder notices to the correct address. His position was that any non-compliant activity with regard to prescribing without authority did not put Ms O'Donnell at risk.

In relation to not accessing DORA as a clinical decision support tool, he indicated that he found no reason to do so and other practitioners treating Ms O'Donnell had similarly not used it.

In relation to the issues raised by the Acting Chief pharmacist, I sought an opinion from Dr Nicolle Ait Khelifa, experienced consultant psychiatrist and addiction medicine specialist. Dr Ait Khelifa reviewed the relevant evidence and declined to criticise Dr Pitt in any significant way. She stated that *"There was a clear focus in the medical notes of Dr Pitt to seek psychological support of Ms O'Donnell's mental health and pain rather than increasing medications. There were no*

documented attempts to reduce oxycodone or lorazepam, however boundaries were held around prescribing of these."

Dr Ait Khelifa stated in relation to Dr Pitt's alleged breaches of the regulatory framework;

> *"There is a regulatory framework designed to control the misuse of Schedule 8 drugs in Tasmania. By Dr Pitt not submitting authorisations as required by the legislation there was no additional oversight of the prescribing. For this regulatory monitoring to be most effective their needs to be clinical support for clinicians such as networks for ongoing prescriber support and engagement, advice, and review readily available as well."*

In this particular case, although breaches by Dr Pitt occurred, I do not consider that there is sufficient connection to Ms O'Donnell's death to enable me to make further comment. I cannot make a finding to the requisite legal standard as to the cause of Ms O'Donnell's death. Further, I cannot find that Dr Pitt should have been aware that she was likely to abuse other substances which, in combination with her long- prescribed substances, might cause her death. He had been treating Ms O'Donnell for a number of years and a solid doctor-patient relationship had been built in which Dr Pitt did not have reason to suspect her of misusing drugs.

I comment that coroners often encounter cases where doctors regularly prescribe Schedule 8 substances without current authorities from PSB to do so, no doubt due to workload issues or insufficient attention to the expiration of the authority.

In his finding into the death of *Melissa Mary Spencer*, Coroner Cooper stated in respect of such breaches by a medical practitioner:

> *"The regulatory system in place is designed to provide a regime which enables the safest possible therapeutic use of narcotic substances by members of the community, recognising that those narcotic substances can have death as a side-effect."*

I comment that prescribers of schedule 8 substances should ensure that they are in possession of current authorities from PSB in respect of their patients. They should also be registered to DORA, have working knowledge of its use, and access it when needed to enhance safe prescribing practices.

I extend my appreciation to investigating officer First Class Constable Olivia Pearce-Tomes for her thorough investigation and report.

The circumstances of Ms Margaret O'Donnell's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Ms O'Donnell.

Dated: 21 December 2021 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner