MAGISTRATES COURT TASMANIA

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 Jennifer May Tilley

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

a) The identity of the deceased is Jennifer May Tilley;
b) Mrs Tilley died in the circumstances set out below;
c) The cause of Mrs Tilley's death is undetermined; and
d) Mrs Tilley died on 8 January 2018 at Kingston, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Tilley's death. The evidence includes:

- The Tasmania Police Report of Death for the Coroner;
- Affidavits confirming life extinct and identification;
- An opinion of the forensic pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Affidavits of four attending and investigating police officers;
- Affidavit of David Collingwood Tilley, Mrs Tilley's husband;
- Affidavit of Samuel John Tilley, Mrs Tilley's son;
- Affidavit of Lynn Margaret Batchelor, Mrs Tilley's sister;
- Medical records/reports from Mrs Tilley's general practitioner and pain specialist;
- Report from the Department of Health's Pharmaceutical Services Branch (PSB);
- Medical review report prepared by Dr A J Bell, coronial medical consultant; and
- Forensic and photographic evidence.

Background

Jennifer May Tilley was born in Latrobe, Tasmania on 6 December 1959 and was aged 58 years at the time of her death. She was married to David Collingwood Tilley and there are three children of the relationship (one deceased in infancy). Mrs Tilley had previously worked as a

social trainer for those with disabilities but had ceased working at the time of her death due to her poor health.

Mrs Tilley was born with ureteral duplication, a rare congenital malformation of the urinary tract. At the age of 17 years, Mrs Tilley had a kidney removed and she suffered abdominal adhesions as a result. As an adult, she suffered from numerous health conditions, including bowel obstruction, coeliac disease, chronic abdominal pain and bile acid malabsorption. Mrs Tilley's numerous health conditions required her to be frequently admitted to hospital and to undergo surgery. The medical needs of Mrs Tilley were complex. She suffered constant pain and she was allergic to a wide range of medications, including narcotic analgesics. It was therefore a very difficult task for her doctors in treating her symptoms.

Mrs Tilley was under the care of her long-term general practitioner, Dr Graeme Jones, who prescribed her regular medication with advice from her rheumatologist and pain specialist, Dr Hilton Francis.

In 2009, Mrs Tilley commenced treatment using pethidine routinely for her gut pain and motility upon the recommendation of Dr Francis. Pethidine is a synthetic opioid analgesic and is a Schedule 8 substance under the *Poisons Act* 1971. Although pethidine is an effective analgesic, there is significant potential for the development of dependence and drug seeking behaviours. It is not commonly used but there were few options in Mrs Tilley's case.

Mrs Tilley was directed to self-administer, subcutaneously, her pethidine infusion over a four hour period. The medical evidence indicates that, particularly in the two years before her death, the pethidine regime improved her functioning in daily life and helped her maintain her weight. However, Mrs Tilley did not always administer the pethidine using the pump over the four hours required, but instead injected the pethidine to give her a burst of energy. At times, Mr Tilley would find his wife unconscious after injecting herself with pethidine.

In his notes of 15 March 2016, Dr Jones recorded that Mrs Tilley engaged in drug seeking behaviour by using her illness to obtain pethidine and by using the medication inappropriately. For this reason, she was required to collect her pethidine on a weekly basis. In his report, Dr Jones said that before her death, Mrs Tilley did not exhibit drug seeking behaviour and was compliant with her medication.

In addition to pethidine, Mrs Tilley's medical records indicate that her other prescribed medications included hydromorphone, escitalopram and temazepam at the time of her death. She last saw Dr Jones on 15 December 2017 for acute bronchitis.

Circumstances surrounding the death

On the morning of 8 January 2018 Mrs Tilley had a telephone conversation with her sister, Mrs Lynn Batchelor. Mrs Batchelor said that Mrs Tilley sounded quite upbeat in the conversation as she usually did after taking her pethidine medication.

At 4.45pm on the same day, Mr Tilley arrived home and noticed that Mrs Tilley's behaviour indicated that she had injected pethidine. He said that she *'had energy…she wasn't stopping or forgetful'*. He then left home at about 5.30pm to assist one of their friends install a security door.

A little after 10.00pm, Mr Tilley arrived home and called out to Mrs Tilley without any response. He then entered the bedroom and found her kneeling on the floor with her head on the bed appearing as if she had passed out. Mr Tilley touched her shoulder and immediately realised she had no signs of life. He said that he knew she had not been injecting pethidine as her pants were up and there was no needle close by. He then telephoned his son, Samuel Tilley, and also dialled 000. He was instructed by the operator to commence CPR upon Mrs Tilley.

Samuel, and subsequently Ambulance Tasmania paramedics, arrived shortly after Mr Tilley's call. CPR was continued by the paramedics but they were unable to revive Mrs Tilley and she was declared deceased. Police officers attended the scene to investigate her death. They observed that Mrs Tilley appeared to have been making the bed when she passed away and there were no signs of violence or suspicious circumstances. They found no medications on the bed or around her. There was no note or writing by Mrs Tilley suggesting that she intended to end her life.

Investigation

On 9 January 2018, an autopsy was performed upon Mrs Tilley at the Royal Hobart Hospital by Dr Christopher Lawrence, State Forensic Pathologist. Samples of her blood were also forensically analysed, the results of which showed a toxic level of pethidine and the presence of

her other medications (citalopram, temazepam, oxazepam, sumatriptan, paracetamol and fluconazole).

In his report, Dr Lawrence stated that the autopsy revealed no clear cause of death. He noted that Mrs Tilley had small adrenal glands and a degree of adrenal insufficiency. In such circumstances, sudden death is possible. However, given the toxicology results, Dr Lawrence indicated that the "potential" cause of death was mixed drug intoxication. Dr Lawrence noted that Mrs Tilley had been a long-time user of pethidine by injection and posited that she had probably developed tolerance towards it. As such, larger and/or more frequent doses would have been required to produce the same pharmacological effects.

It is evident from Mrs Tilley's medical records at the time of her death that she was not prescribed citalopram and nitrazepam, substances found in her blood. These are central nervous system depressants that when used in conjunction with pethidine and other prescribed central nervous system depressants (temazepam, oxazepam and sumatriptan) can result in central nervous system depression and an increase risk of serotonin toxicity.

Although pethidine was detected at a toxic level, a degree of caution is required when interpreting the significance of this result. This is because tolerance to central nervous system depressants, such as pethidine, develops over time, particularly with long-term use. It does appear that Mrs Tilley injected pethidine on the day of her death but it is not clear that pethidine toxicity caused her death directly, particularly given her general poor state of health. It is plausible that adrenal insufficiency or another issue associated with her medical conditions may have been the main cause of her sudden death.

I therefore cannot determine the cause of her death with any certainty, although I am satisfied that she did not intend to end her life.

Comments and Recommendations

An issue arising for consideration in this investigation is whether the prescribing of pethidine to Mrs Tilley by Dr Jones was appropriate and properly monitored, particularly in light of her tendency to misuse the medication and its possible role in her death. In this regard, I sought a report from the coronial medical consultant, Dr Anthony Bell.

In his report, Dr Bell stated as follows:

"In this complex case, the medical practitioners have provided good care. The use of narcotic drugs to control gut issues was a sound practice in this specific situation. The patient was intolerant of many of the narcotic drugs and eventually, Pethidine was found to be tolerable and work. Using the drug by infusion was to prevent high blood levels that occur after a rapid injection. The patient preferred injections as there were less expense and the higher drug levels are known to cause a euphoric state."

I accept the opinion of Dr Bell that the prescribing regime was appropriate and, in this regard, I acknowledge that the medical conditions suffered by Mrs Tilley presented a challenge to her treating professionals. As such, I make no criticism of Dr Jones or Dr Francis in respect of their overall treatment regime.

I have received a report from the Tasmanian Department of Health's Pharmaceutical Services Branch (PSB) in respect of the supply of medication to Mrs Tilley. 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. Pethidine 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. Mrs Tilley was declared drug dependent and drug seeking under the *Poisons Act* by Dr Jones. Accordingly, authorities were required to allow prescribing to her.

In the PSB report, the Acting Chief Pharmacist records that that there were numerous breaches of the *Poisons Act* 1971 in relation to the supply of Schedule 8 substances to Mrs Tilley from 2012. Many of these breaches related to prescription supplies by Dr Jones or his practice colleagues where prior authorities had expired, and further authorities had not been sought as required. Two breaches related to staged supply conditions not being adhered to.

I also note from the PSB report that Dr Jones had no access and had not made contact with PSB to register to the associated permit system (*Drugs and Poisons Information System Online Remote Access* (DORA)) in prescribing to Mrs Tilley. This system is not mandatory for general practitioners but helpfully provides access to Department of Health databases so that they may

view clinical information and dispensing data relating to Schedule 8 substances in respect of any patient.

In his finding into the death of *Melissa Mary Spencer*, Coroner Cooper stated in respect of similar *Poisons Act* 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."*

Unfortunately, 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 this case, there is no evidence that any prescribing breaches occurred in the immediate period before Ms Tilley's death.

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 convey my sincere condolences to the family and loved ones of Jennifer May Tilley.

Dated: 17 December 2021 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner