IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 3133

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: SUSAN INGRID ROBB

Delivered On:	28 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	25 March 2014
Findings of:	PHILLIP BYRNE
Representation:	Ms Jan Moffatt (solicitor) for North Western Mental Health Service
Police Coronial Support Unit	Senior Constable Amanda Maybury

I, PHILLIP BYRNE, Coroner having investigated the death of SUSAN INGRID ROBB

AND having held an inquest in relation to this death on 25 March 2014
at Coroner's Court of Victoria, Level 11, 222 Exhibition Street Melbourne
find that the identity of the deceased was SUSAN INGRID ROBB
born on 30 November 1973
and the death occurred on 20 August 2011
at Northern Hospital Psychiatric Unit, The Northern Hospital, 185 Cooper Street, Epping 3076

from:

1 (a) MIXED DRUG TOXICITY (METHADONE, DIAZEPAM, CLONAZEPAM, AMISULPRIDE, OLANZAPINE, HALOPERIDOL, CHLORPROMAZINE AND VALPROIC ACID)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Susan Ingrid Robb, 37 years of age at the time of her death, was a patient at Northern Hospital Psychiatric Unit. Ms Robb had previously been receiving case management/treatment on a Community Treatment Order (CTO) by North West Area Mental Health Service, Mobile Support and Treatment Team prior to being conveyed by police to the Emergency Department at Northern Hospital on 18th August 2011. Ms Robb was taken to Northern Hospital following two weeks of "precipitously deteriorating mental state". Ms Robb had her CTO revoked and was admitted as an involuntary patient. In his statement to the Court Ms Robb's inpatient psychiatrist Dr Kurt Wendelborn, Deputy Director Clinic Services, Northern Area Mental Health Services, enumerated the suspected bases of Ms Robb's deterioration and subsequent hospitalisation.

    a) Self-ceased methadone maintenance program (last prescribed on the 27/7/2011, dose 40mg).

    b) Escalation of amphetamine and alcohol use

    c) Hostility and intimidating threats to MST case manager, police and CATT services: e.g. made direct threats to "cut clinician's throat"

    d) Non-adherence with prescribed psychotropic medications

    e) Recent family stresses

f) Recent assault from ex-partner (father of Susan's daughter)

g) Recent change in treating team membership (Case manager had left post as had a person associated with her residential service).

h) Recent abrupt departure from usual place of residence, possibly lodging with niece

2. Ms Robb had a long, complex past history of Schizoaffective Disorder, mixed Borderline and Anti-Social Personality Disorder, had been substance dependent (benzodiazepine, alcohol, cannabis, amphetamines & heroin) together with an unfortunate history of intentional self-harm, suicide ideation and opioid overdoses.

3. Ms Robb's General Practitioner, Dr Marcus Weyland was authorised to prescribe methadone to his patient. The last dose of 40mg was dispensed and taken at Brunswick Pharmacy on 28th July 2011. For reasons which are not clear to me, Ms Robb abruptly and unilaterally decided to cease her methadone therapy from that date.

4. When reviewed by Dr Wendelborn in the Intensive Care Area (ICA) on the morning of 19th August 2011 Ms Robb was described as follows:

> *"Her manner in the interview was restless, driven and dis-inhibited, she was often distracted, her speech was loud, rapid and difficult to interrupt; her thought showed flight of ideas and some loosening of associations, the content was as noted above; angry, despairing, needy and hinted at suicidal ideas. Her affect was labile and irritable in the extreme, her judgment was markedly impaired."*

She "pressed" the treating team for some medication to "calm me down before I do something crazy".

5. Subsequently, on the ward Ms Robb's presentation was described as *"restless", "forward", "demanding", "loud, coarse and intermittently verbally abusive*"; I think it fair to say Ms Robb was at times troublesome (my expression). Ms Robb was described as alternating between "*periods of sustained high arousal*" and periods of "*drowsiness as a consequence of prescribed sedative medication*" (Dr Wendelborn's words).

6. In his statement Dr Wendelborn states that Ms Robb's previously prescribed psychotropic medications were restarted on 19th August 2011 (Olanzapine, Amisulpride and Lithium) with Clonazepam and Sodium Valporate added. It is further stated that on that same day, after consultation with Dr Helen Sweeting, the Drug and Alcohol Clinical Advisory Service

(DACAS) Addiction Specialist, "*methadone was re-instated.*" It is claimed the re instatement of Methadone was "at Susan's request". That decision has been the subject of considerable attention in my investigation, as the basis, or perhaps more accurately the bases upon which that decision was taken troubled me.

7. Mrs Ellen Henderson, Ms Robb's mother wrote a letter to the Coroner expressing "grave concerns" she had, even prior to her daughter's death, that the amount of medications administered to Ms Robb was excessive. She stated:

> *"I knew she was very heavily medicated and that this amount of medication was not safe"*

8. In his statement Dr Wendelborn conveniently set out the various medications prescribed to Ms Robb throughout her inpatient stay at Northern Hospital Psychiatric Unit; he noted all medications were taken orally; I list them here:

1. Amisulpiride 200mg BD
2. Olanzapine 10mg TDS + 10 mg PRN (received 2 doses on 19th and 1 each on 20th, 21st and 22nd)
3. Lithium Carbonate 950 mg BD
4. Clonazepam 1mg QID + 1 mg PRN (received 5 doses on 19th, 3 doses on 20th, 2 on 21st and 1 on 22nd)
5. Methadone restarted at 20 mg and increased by 10 mg daily to 50 mg on 22nd.
6. Sodium Valproate 500 mg BD titrating to 1000mg BD over 3 days
7. Chlorpromazine 25 mg Pro Re Nata (received 2 doses on 20th and 3 on 21st)

9. I turn to the issue of the re-instatement of methadone therapy after a period of three (3) weeks without the therapy. In her statement to the Court Dr Sweeting makes a pertinent comment, when she stated:

> *"DACAS is a phone based consultation service staffed by addiction specialists with the aim of providing general advice to clinicians managing patients with alcohol and drug problems. Advice provided by DACAS consultants can only be based on what is presented at the time of the call and caveats to this effect are provided at the time of the call. As such the advice has to be general and is always accompanied by a*

caveat that states that this is only phone advice and is limited to what can be gleaned by information provided by phone, and clinical decisions are the responsibility of the clinician(s) managing the patient."

10. As indicated in the note, one of the treating team wrote in the medical record after consultation with Dr Sweeting there was a important proviso to her advice; the re-commencement of methadone was predicated upon "...if evidence of opiate withdrawal". The same proviso appears in management plan "...if evidence of withdrawal". The decision to re-introduce methadone was a "clinical judgement" that Ms Robb was experiencing some degree of opioid withdrawal. As to this issue, Associate Professor Michael McDonough, Chief Clinical Advisor: Addiction Medicine, Department of Health, an expert witness who reviewed the case, conceding the judgement call is a "challenge", said:

> *"...sedatives reduce, and may mask, some of the signs and symptoms of opioid withdrawal. While a skilled/specialist clinician may be able to identify specific signs that confirm opioid withdrawal, many clinicians unfamiliar with opioid withdrawal would likely find this very difficult. Further, the case details do not suggest that Ms Robb had relapsed to a state of Opioid Dependence by the time of her admission and, in my opinion, it would be unlikely that Ms Robb had re-developed clinically significant Opioid Dependence within a few weeks, such that could give rise to notable opioid withdrawal signs."*

11. As to the re-initiation of methadone, in his statement to the Court Dr Wendelborn claimed:

> *"The methadone was reinitiated at Susan's request after re-registration and consultation with the Drug and Alcohol Service addiction specialist who recommended a starting dose of 20 mg increasing by 10 mg a day to a maximum dose of 40 mg if Susan showed signs of withdrawal. Susan had 20 mg on the 19th, 30 mg on the 20th and 40 mg on the 21st for subjective symptoms of withdrawal and craving. This dose was increased further following a review on Sunday the 21st by the On-Call Senior Registrar who found Susan to be very aroused, restless and overwrought, irritable, angry and disorganized, such that on the morning of Monday the 22nd Susan received 50 mg. This was reviewed following her morning administration and reduced again to 40 mg by her regular treating team."*

What struck me immediately was the suggestion that methadone was re-introduced "at Susan's request;" Ms Robb at the time was a severely psychiatrically unwell patient, so that informed consent to the treatment (if that is what is implied) is at best problematic.

12. I was increasingly concerned that the criteria for re-introducing methadone treatment was not sufficiently demonstrated. My tentative view was that it was unclear at that time that Ms Robb was experiencing symptoms of opioid withdrawal. It was unclear to me on what basis /or bases those treating Ms Robb had assessed her as opioid dependant. Furthermore, I had concerns that the combination of medications, including a number of benzodiazepines, increased the risk of over sedation and toxicity.

13. From the outset, leaving aside whether re-introduction of methadone was appropriate or not, I was concerned about the rate of increase, especially the doses administered on 21st and 22nd August 2011. There are references in the notes of instances where Ms Robb was quite heavily sedated. That and the circumstances in the hours leading to her death raised concerns as to the efficacy/adequacy of the monitoring process.

14. I interpolate that I only took over carriage of the matter on 13 September 2013 when the coroner who previously had carriage of the matter indicated she intended to retire and was unlikely to be able to complete her investigation during her tenure. Not having the management of the matter from the outset brings with it several difficulties. My first concern was the lack of progress of the 2011 matter, which due to the circumstances of Ms Robb, as an inpatient, meant it had to proceed as a mandatory inquest. I determined to progress the matter as soon as possible.

15. To that end I sought and received permission from the State Coroner to obtain an independent expert opinion. Associate Professor Michael McDonough was commissioned by the court to provide an expert opinion.

16. The expert opinion (the report) was received at the Court on 29 November 2013 and was made available to the interested parties: Five specific questions relating to Ms Robb's medical management were addressed to Dr McDonough, who responded to each one. For a better understanding of Dr McDonough report I list in this finding the five (5) questions posed:

    1. Was the commencement of Susan Robb on methadone while she was an inpatient at the Northern Psychiatric Unit clinically appropriate? Please provide an explanation regarding clinical appropriateness.

2. Susan Robb was commenced on methadone on 19 August 2011 at a dose of 20 mg daily. She was given a daily dose of 20 mg plus another 10 mg PRN order on 20 August 2011. In what circumstances is it clinically appropriate to give a PRN order for methadone once a dosing regime has been established?

3. On 21 August 2011 the daily dose of methadone for Susan Robb was increased to 40 mg, then 50 mg daily on 22 August 2011 (the day she died). Was the rate of increase of the methadone clinically appropriate given the instruction from the addiction medication specialist (Dr Sweeney) that the dose should be titrated upwards on signs of opiate withdrawal? [Dr Sweeney should be Dr Sweeting]

4. Is there evidence in the clinical file that Susan Robb suffered opiate withdrawal? If so, where was it monitored and recorded?

5. Given Susan Robb's presentation, would you consider it appropriate that when commencing methadone in combination with other medications, that a process is put in place to assess whether she suffered opiate withdrawal (Dr Sweeney's indicator for dose increase) to inform decisions around whether the methadone dosage should be increased and to monitor her level of sedation? Is there evidence that such a process was put in place? [Dr Sweeney should be Dr Sweeting]

Each of the questions are to some extent inter-related.

17. In broad terms, Dr McDonough expressed considerable reservations about aspects of Ms Robb's treatment. He opined that the commencement of Ms Robb on methadone while she was an inpatient was "unlikely to be clinically appropriate". Dr McDonough said:

> *"Within the clinical notes provided, I could not find evidence to suggest there was a specific clinical indication to recommence Methadone treatment or that any discussion about the merits of re-commencing Methadone treatment might have occurred. Referring to both the National Opioid Pharmacotherapy Clinical Guidelines and the Victorian Clinical Guidelines ("Policy for maintenance pharmacotherapy for Opioid Dependence" published by the Victorian Department of Health), the indications of Methadone treatment include that Ms Robb had relapsed to injecting Heroin, that there were signs of recent injecting marks, a urine*

drug screen had been collected to corroborate recent Heroin or other opioid continuing use, and that Ms Robb demonstrated signs of opioid withdrawal. All of these indicators help confirm that such a patient is Opioid Dependent and whether they have been recently injecting; the confirmation of current/active Opioid Dependence is deemed essential before starting treatment with Methadone. However, none of this type of information is indicated in the clinical notes provided and it remains impossible to ascertain why Methadone treatment was instituted."

18. In light of the general tenor of his report together with a desire to progress the matter, I listed it for a Mention/Directions Hearing on 5th February 2014. At that hearing Mrs Ellen Henderson (Ms Robb's mother) appeared unrepresented and Ms Jan Moffatt of Donaldson Whiting and Grindal solicitors, appeared for North Western Mental Health. Having made some opening remarks I enquired of Ms Moffatt if she had instructions to make any "concessions" as to the efficacy of Ms Robb's management/treatment. Ms Moffatt said some of Dr McDonough opinions had been noted, but she would have to take further instructions from her client prior to indicating whether any "concessions" might be forthcoming. I adjourned the Mention/Directions Hearing to 25 March 2014 indicating that depending on her further instructions I would on that day determine the future course of the matter; by that I meant consider at that time whether the matter would need to proceed to formal open public inquest with witnesses to be called for examination and cross examination.

19. Prior to the resumed hearing Ms Moffatt provided the Court with a response from Associate Professor Suresh Sundram, Director of Clinical Services Northern Area Mental Health Services. The first point made by Dr Sundram went to the issue of cause of death. Not unreasonably he seized on comments made by Senior Forensic Pathologist Dr Matthew Lynch who, upon coronial direction, had performed the autopsy at Victorian Institute of Forensic Medicine. In the final paragraph of his letter Dr Sundram maintained that "it is not possible to be definitive about the reasons for Ms Robb's death". I agree, however, in coming to a conclusion as to the cause of Ms Robb's death the cause does not have to be definitively established; the appropriate standard of proof to be brought to bear is the balance of probabilities. I indicated to Ms Moffatt that if I had to make a finding as to which of Dr Lynch's hypotheses/theories was more likely, the evidence of Ms Robb's condition in general and in particular in the few hours before the Code Blue was called

would tend to support the respiratory depression theory. Interestingly, as to that issue Dr Sundram makes an interesting, what I will call, concession when he says:

> *"As noted above, it is not possible to quantify the contribution of the methadone to Ms Robb's death; however, it is likely to have contributed at least partially to death only from the first proposed mechanism."*

That conclusion would, I suggest, be virtually impossible to resist.

20. I note the following acknowledgement offered by Dr Sundram:

> *"We fully acknowledge Associate Professor McDonough's comment that an informed discussion about the re-commencement of methadone was not undertaken with Ms Robb. However, it was not possible due to her acutely unwell mental state to engage Ms Robb in an informed discussion concerning her treatment; ...."*

However that statement does not, in my view sit well with the following paragraph where it is stated:

> *"... we relied on the clinical judgement that she was experiencing some degree of opioid withdrawal; that her demands for methadone were indicative of consent (my emphasis); and that she was at imminent risk of relapse to heroin use upon discharge."*

In his letter Dr Sundram, by implication at least, concedes that *"standard protocols used in drug and alcohol settings are not useful for a considerable proportion of patients in acute psychiatric settings".*

As stated earlier in this finding, I am not persuaded Ms Robb was in any condition to provide an informed consent, real or implied.

21. At paragraph 5 of his response Dr Sundram says:

> *"Both Associate Professor McDonough and Dr Sweeting recognise the use of pro re nata (PRN) methadone in a situation of opioid withdrawal. In this regard we relied upon Dr Sweeting's contemporaneous advice of no more that 10 mg to be administered and I note that only a single dose was ordered on the 20/8/11 and was administered."*

One has to recall the caveats Dr Sweeting put on the basis of her advice:

"The decision to prescribe methadone is made by the treating team. The DACAS consultation role is to provide secondary phone support. Thus the decision to treat with methadone ultimately rests with the treating team who are clinically managing the patient, and not with DACAS consultants."

I note in her statement that the rationale for recommencement of methadone in this case would be based on clinical guidelines for the prescribing of opioid pharmacotherapy. In his response Dr Sundram conceded the methadone dosages were "too great and not clinically appropriate". I agree with that frank concession.

22. The second Mention/Directions Hearing was listed for March; again Mrs Henderson was present as was Ms Moffatt of Donaldson Whiting and Grindal.

I again stressed my role was not to lay or apportion blame but to establish the facts and then consider whether the facts as found represented causal factors in the death of Ms Robb.

At the hearing, Associate Professor Sundram's letter was available. After some discussion, I indicated that the concessions contained therein were in my considered view sufficient so that further investigation was not warranted and I could proceed to conclusion without recourse to the full forensic judicial process. However, formal inquest was mandatory; that requirement could be fulfilled by way of what the Court calls a "summary inquest" that is, the formal opening of the inquest, the mere tendering of the Brief of Evidence by the member of PCSU assisting the coroner, without the need to hear *viva voce* evidence. The formal finding would then be made "on the papers". This prospect was discussed with both Mrs Henderson and Ms Moffatt both of whom agreed that course of action was appropriate in the circumstances. I then adjourned the Mention/Directions Hearing, opened the inquest into the death of Susan Robb and the Brief of Evidence was formally tendered. I indicated I would prepare a formal finding as soon as practicable. The inquest was then adjourned to a date to be fixed for the formal delivery of my finding.

CONCLUSION

23. It is clear that there were aspects of Ms Robb's care/treatment/management that were not in accordance with either the 2003 National Opioid Pharmacotherapy Clinical Guidelines or the Department of Health Policy for Maintenance Pharmacotherapy for Opioid Dependance. The inescapable conclusion is that there were omissions and departures that were contributing factors in Ms Robb's death.

24. There is one matter I wish to make clear – while I have found some significant deficiencies in management I do not suggest the medication regime (by that I mean the raft of medications, including methadone) administered to Ms Robb were given to manage a difficult, sometimes troublesome patient, but were prescribed and administered in good faith in an endeavour to treat Ms Robb's complex conditions.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. Dr Sundram conceded:

> *"...the untimely death of Ms Robb has highlighted for us gaps in the understanding and treatment of opioid withdrawal in people with severe and acute psychiatric disorder."*

The final paragraph in his letter is important because it goes to the coroners prevention role, I include the final sentence.

> *"We have implemented additional training to junior medical staff regarding management of drug withdrawal; provided additional training to nursing staff regarding physical observations after the administration of sedating medications; and are working with Dr Cementon to develop and implement appropriate methods of monitoring for opioid withdrawal in psychiatrically unwell people."*

2. At the summary inquest Ms Moffatt gave the court an assurance she would follow up on Dr Sundram's indication that work was being undertaken in consultation with Dr Enrico Cementon to refine/revise North Western Mental Health's practices, procedures, guidelines and training to address some of the shortcomings observed in relation to treatment of opioid withdrawal in patients with severe acute psychiatric illness. Ms Moffatt has provided the court with a copy of a letter from Mr Peter Kelly, Director Operations, North Western Mental Health which includes a undertaking that the revised protocol or guideline will be incorporated into a Clinical Risk Management Bulletin which will be distributed to the clinical workforce. I accept that assurance. I do not wish to further delay this 2011 matter, so propose to deliver this finding and note in it the assurance/undertaking given by Mr Kelly.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

I acknowledge input from the Coroners Prevention Unit, Health and Medical Investigations Team (HMIT).[1]

To increase the safety of patients in the Northern Hospital Psychiatric Unit, the training program for the safe use of opioid therapies should be referenced to the 2013 *Department of Health Policy for maintenance pharmacotherapy for opioid dependence*, and the 2003 *National clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence.* Specifically, the training program should address the knowledge and skills of medical and nursing staff regarding:

- Informed consent and patient information
- Safe prescribing of methadone pro re nata (PRN)
- Appropriate monitoring of patients prescribed methadone or alternate pharmacotherapies, especially the level of sedation
- Specific education of the 2011 *North Western Mental Health Alcohol and Other Drug Withdrawal Practice Guidelines*

[1] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

I direct that a copy of this finding be provided to the following:

The Family of Susan Robb

North Western Mental Health

Office of the Chief Psychiatrist

Department of Health

Signature:

PHILLIP BYRNE
CORONER
Date: **28 May 2014**